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ABDOMINAL INJURIES—SYMPTOMS, TREATMENT, CASE REPORTS.

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Owing to the rapid increase in the population of our city, its attendant traffic congestion, over-crowded tenderloin districts, and other accident-provoking conditions existing in thriving cities, the past two years have given us a great variety and number of abdominal injury cases. Out of some two hundred and sixty such cases, I have drawn the conclusions which I am giving below. And in passing, I would say that too much attention cannot be given to the making of a diagnosis in cases of injury to the abdomen.

Injuries to the abdomen may be classified as extra and intra-abdominal wounds. Conditions generally encountered in the former are contusions and lacerations of various degrees. Ruptures of the muscles are rare.

The cardinal symptoms of extra and non-perforated abdominal wounds are often so closely allied that great precaution must be taken in drawing conclusions.

The symptoms of contusions are abdominal rigidity, labored respiration, pulse rapid but of good quality, pain not localized but general; and in the more severe forms there may be vomiting of the stomach contents, free from blood. Patient is conscious, and does not suffer from general systemic shock.

TREATMENT.

Close observation for twenty-four hours to note any change in the pulse rate, decrease in temperature, or persistent or localized pain; excreta and vomitus examined carefully to detect any evidence of blood; hematomas and swellings usually disappear under pressure—an ice bag may be applied. In the event of an

abscess forming, it is treated in the usual manner.

Treatment of Lacerations.—The surrounding skin area thoroughly cleansed; foreign bodies carefully looked for and removed; a weak solution of iodine poured into the wound; bleeding points controlled; the wound sutured with drainage, if necessary.

Intra-abdominal wounds are divided into two classes, viz: penetrating and non-penetrating.

The symptoms attending both these divisions are practically similar. Of course, the former, with its wound of entrance, makes diagnosis less difficult. Systematic shock is invariably present, with marked rigidity of the abdominal muscles; hemorrhage is indicated by an increase in rate and volume of the pulse, by pallor, by low blood pressure and decrease in temperature, which is often sub-normal; blood in the vomitus, urine or stool; pain is a valuable sign, especially when localized; dullness in the flanks is usually indicative of blood or intestinal contents. In making diagnosis, it is well to catheterize the patient, and also to administer a simple enema for the detection of blood.

Perforated wounds are caused, as a general rule, by bullet perforation or stabs; in the latter case there may be an escape of blood or excreta, or protrusion of the bowel. In a contusion or slight wound of the abdomen, there may be extensive visceral involvement.

In this connection, I recall the case of a patient who had been shot in the abdomen. He was placed under arrest without disclosing the fact of his injury, and after having spent twelve hours in jail, was discharged; an hour after reaching his home, he fell to the floor exhausted and was removed to the hospital. We operated immediately and found his abdominal cavity filled with blood, and twelve perforations of the bowel. He died two hours later.

I cite this case merely to show that, unless an extremely careful and thorough examination is made, internal hemorrhage and perforations

may be present for many hours without manifesting any objective symptoms.

Treatment.—It is imperative that the attention should be first directed to combating shock; inasmuch as we usually find the pulse rate in these cases very weak, often imperceptible, it is necessary to bring about a change in its volume. The value of intravenous injections of normal saline solution at this time cannot be over-estimated, the amount varying with the pulse reaction; cardiac stimulants are also of value; plenty of heat in the form of hot water bottles and warm blankets. During the time this preliminary treatment is being administered, the patient's abdomen is being surgically prepared, and as soon as his condition will permit, the operator begins.

In a stab wound, the intra-abdominal pressure very often forces out much bowel through a small opening; in these cases the bowel frequently becomes strangulated—heat should be applied immediately to the bowel and the strangulation released.

The entire cavity may be filled with blood clots. The control of the hemorrhage now occupies the surgeon's attention. The vessels of the mesentery and omentum are often severed; with the free bleeding controlled and the rents in the omentum closed, the perforations of the viscera are now systematically looked for and closed. If the laceration is extensive, or perforations grouped, as is often the case in bullet wounds, a resection of that portion is indicated. If the condition of the patient will not warrant this extensive procedure, the loop of bowel may be brought through the wound at the time of closure and a rectal-fistula will result, which may be cared for at a later stage. Ample drainage is now inserted, and the wound is closed in the regular manner. Post-operative treatment consists in stimulation; hypodermoclysis when necessary; elevation of the foot of the bed, with plenty of heat to the body.

Stomach holes can be closed with purse strings or infolding sutures. There is danger of stenosis if the perforation is near the cardia or pylorus, which necessitates a gastro-enterostomy. Perforations may involve one or both walls: the posterior wall is most conveniently reached and sutured through the anterior opening.

Liver Lacerations.—This condition often gives rise to troublesome hemorrhage; a wide mattress suture usually controls this, but I have derived the best results from the gauze pack.

The spleen, pancreas and bladder should be considered in this classification. I have, how-

ever, had little experience with these organs in the cases from which I have drawn my conclusions.

CASE REPORTS.

CASE 1. J. C. Male. Age 24 years. Admitted January 25, 1916. Stab wound of the abdomen, with much bowel protruding and partly strangulated. In a severe state of shock. Pulse 150; temperature 97; respiration shallow.

Treatment.—600 CC. Normal Saline solution. Heat applied to exposed bowel; stricture released; deep epigastric artery severed and controlled; two perforations of the bowel repaired; bleeding points in omentum controlled; drains inserted.

Patient now employed at Ford Motor Car Company.

CASE 2 E. D. Female. Age 33 years. Admitted June 3, 1916. Gun shot wounds in chest and abdomen. Two bullets entered the left lung and the third abdominal wall. Patient showed no symptoms of perforation, so was put to bed immediately. X-ray examination disclosed that the bullet which entered the abdominal wall was lodged just below the crest of the ileum, and was causing no trouble.

Patient was discharged in twelve days.

CASE 3. S. M. Male. Colored. Age 28 years. Admitted March 18, 1917. Shot in abdomen. In severe condition of shock; firm rigidity of abdomen. Pulse imperceptible; temperature 97.40; respiration shallow; single wound of entrance; laparotomy disclosed cavity filled with blood and intestinal contents; twenty-two perforations of the bowels and a four inch laceration. Perforations were repaired and eight inches of bowel resected. Closure with drainage.

Patient died two days later.

CASE 4. J. Mc. Male. Age 35 years. Admitted October 7, 1916. Shot through abdomen, bullet entering lumbar region with exit above umbilicus. Patient conscious; pulse 110; temperature 98; respiration labored and shallow. Laparotomy disclosed perforation of stomach at pylorus, and three perforations of the bowel. These were repaired in the usual manner, and a gastro-enterostomy performed.

Patient improved for several days, then developed pneumonia and dies three weeks later.

THE CORRECT INTERPRETATION OF BLADDER SYMPTOMS IN THE FEMALE.

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Bladder symptoms in the female occur under the same conditions of bladder and kidney disease as in the male and in addition often present themselves when the disease is in the female sexual organs and when the bladder itself is unaffected. A patient complains of frequent micturition, burning pain and tenesmus immediately following micturition, etc. It is evident that these are the symptoms of cystitis

and the problem presented to the physician is to discover the cause of the symptoms. The cause may be any of the following conditions:

Infection of any portion of the urinary tract; disease or displacement of the uterus or its appendages; irritable caruncle of the urethra; new growths in the bladder; stone in the bladder, and the symptoms are often simulated in hysteria and diabetes. The first procedure after obtaining the history in such a case is to secure a specimen of urine with the catheter and subject it to a microscopical examination. The presence of pus denotes urinary infection, its absence at least demonstrates that cystitis is not present. Error sometimes occurs from dependence upon a voided specimen of urine as that is frequently contaminated by vaginal discharges.

The urine being found free of pus the presumption then is that the bladder symptoms are caused by disease in the pelvic organs and a physical examination will reveal whether this is true or not and at the same time suggest the appropriate treatment. Very distressing bladder symptoms often occur from the presence of endometritis, uterine displacements, uterine tumors, ovarian tumors, etc. Inspection will also determine the presence or absence of an irritable caruncle. Occasionally distressing bladder symptoms, severe tenesmus and frequent micturition occur without pus in the urine and without any evidence of pelvic disease. In these cases the urine is intensely acid and it should be suspected that there is an infection of the pelvis of one kidney, with blocking either temporary or permanent of the ureter. I had a patient several years ago in which these symptoms had persisted most of the time for seven years, during which period various physicians had performed all sort of operations upon her pelvic organs without in the least improving her condition. At times she had pus in the urine, but most of the time there was no trace of it. She was eventually found to have tuberculosis of the right kidney, the left being normal, and complete recovery followed removal of the diseased organ. If the urine is found loaded with pus appearing in masses with an alkaline reaction it may reasonably be inferred that the trouble is cystitis without kidney complications. Many cases appear in which the symptoms and appearance of pus are intermittent, in which event it is reasonable to suspect infection in one kidney alone. The infective agent should be determined by culture of the catheterized urine and many cases can be cured by appropriate local treatment and the use of autogenous vaccines. Only the pus pro-

ducing germs can be discovered in this way and as these organisms also occur in most cases of tuberculosis of the urinary track it often is very difficult to recognize the presence of the tubercle bacilli. It is advisable when this organism is suspected, to have a specimen centrifuged daily for a week or more and the pus stained for tbc. Failure to find these, however, does not absolutely settle the question. A case proving obstinate to ordinary treatment requires further investigation and this is made with the cystoscope and ureteral catheter. Much can be learned by an experienced investigator with the cystoscope alone. The bladder should first be thoroughly irrigated and a local anesthetic instilled. Rarely with nervous patients or very irritable bladders a general anesthetic will be required.

The administration of Methylene blue for twelve hours before the examination will be found a valuable procedure. The bladder having been thoroughly irrigated it is comfortably filled with clear water and the optical attachment introduced. With the modern instruments the bladder wall can be thoroughly inspected and its condition determined with certainty. If papilloma or other growths are present they may be easily recognized. The mouths of the ureters can usually be easily located, especially if urine is coming down from both kidneys and Methylene blue has been administered for the mucous membrane around the opening will be found stained, also the blue urine may easily be seen emerging intermittently from the ureteral orifice. The beginner must not too readily assume, however, that one kidney is not functioning because he does not see the fluid escaping during his period of observation. As one of my cases illustrates, it sometimes requires considerable time before the flow appears through a ureteral catheter even when the kidney is in fairly good condition. Inspection of the bladder having been completed the next procedure, in appropriate cases, is to introduce the ureteral catheters. The patient's symptoms, or the appearance of the ureteral orifice may have suggested that the disease exists in a particular kidney, but it is quite important that the urine be obtained from each kidney for in many cases when operation is indicated it is of the utmost importance to determine whether or not one kidney is sound.

The catheters having been introduced the cystoscope may be removed and the urine allowed to drop in sterile glasses, the catheters being marked to denote the respective kidneys they are draining. The separate urines should then

be examined microscopically and bacteriologically and the exact condition demonstrated.

While this paper does not deal with treatment I cannot resist saying that irrigation of the pelvis of the kidney while the catheter is in place is a very valuable therapeutic procedure in all cases of pyelitis due to ordinary pus producing organisms.

The procedures thus outlined—urinary examination, physical examination, cystoscopy, ureteral catheterization with microscopical and bacteriological studies of the excreted fluid, can be depended upon in practically all cases to furnish scientific interpretation of all bladder symptoms.

The following cases histories illustrate particularly the advantage of the ureteral catheter:

CASE 1. Mrs. G. aged 68, complained of the usual symptoms of cystitis. She stated that she had been afflicted with these symptoms at intervals for many years, had been treated with bladder irrigations, diuretics, and vaccines without permanent relief. I found that she had acid urine, a small amount of pus, no casts nor albumin. She entered the hospital and remained in bed for a few days. Bladder irrigations were used which reduced the irritability, culture of urine revealed the colon bacillus present. She was given vaccines and urotropin. Improvement took place rapidly and the pus disappeared. I was about to permit the patient to leave her bed when the pus reappeared suddenly in considerable amount with albumin. This admitted of but one explanation. One of the ureters had been blocked. I administered Methylene blue in the evening and the following morning introduced the cystoscope. Blue urine was readily seen passing from the left ureter. Catheter was passed and the urine found to be normal. The mouth of the right ureter was discovered with more difficulty and no urine was seen passing from it. A catheter was passed without difficulty and the cystoscope was withdrawn. No urine appearing sterile water was carefully injected through the catheter in small amounts. There was no return for a considerable time and after an hour and a half I was on the point of withdrawing the catheter and pronouncing the kidney functionless and recommending its removal when suddenly a blue fluid appeared and in a very few minutes an ounce was obtained. I then irrigated the kidney with a solution of alphozone and removed the catheter. The urine was found to contain much pus. A repetition of the kidney pelvis irrigations several times cleared up the pus completely. This was undoubtedly a case in which the clumps of pus blocked up the small catheter for a time.

CASE 2. Mrs. T., aged 40, had suffered for many years with recurring attacks of pain in the right side followed by painful and frequent urination. She had been treated by many excellent physicians and been examined at one of the great clinics of the country. I found that the cystoscope had never been used and that her urine contained pus. So after administration of Methylene blue I made the examination. The catheter passed readily up the

left ureter and revealed normal urine. It passed as readily for two inches up the right and I could at that time pass it no further. I obtained smaller catheters and at subsequent attempts passed the stricture, also another one five inches from the ureteral orifice. The urine obtained was blue and contained pus cells. The treatment was repeated several times, the urine became clear and for five months there has been no return of her attacks of pain.

All of the usual conditions causing bladder symptoms have now been referred to except calculi in the ureter and the kidney pelvis. Positive diagnosis of this condition is oftentimes difficult because the symptoms produced are the same as those caused from blocking of the ureter from stricture or clumps of pus. The ureteral catheter or wax tipped bougie may render the diagnosis positive. This method being applicable in females by Kelly's method of catheterization, but in many cases exhaustive X-ray studies will be required while a catheter is *in situ* that is impermeable to the X-ray. It is not sufficient to use the X-ray without the catheter for it frequently happens that shadows appear near the ureters, but not in them, which without the presence of the catheter would be mistaken for ureteral stones.

CONTRIBUTIONS TO MEDICAL LITERATURE BY THE PROFESSION OF DETROIT DURING THE LAST SIXTEEN YEARS—(1900-1915 BOTH INCLUSIVE).*

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At the last session of the Congress of Physicians and Surgeons, which meets every three years in Washington, I had occasion to mention the name of one of our well-known colleagues. The question came back, "Who is he?" "What has he written?" "Never heard of him." In attempting to answer these questions, the thought occurred to me, "What has he written, in short, what has any of us, all of us, written, what have been our contributions to medical literature during the last two decades?" Perhaps it is not so surprising that we are not better known away from home, because we have paid too little attention to the literary side of our profession. At any rate, an investigation of our medical contributions to the literature could do no harm, and might lead to some interesting and important discoveries.

The method of attack was to obtain authentic lists of the medical profession of Detroit each year for a certain number of years back and then search the records for their contributions. This was done by using Polk's Medical

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Directory, the A. M. A. Medical Directory, as far back as published, and then searching the Index Medicus and the French substitute *Bibliographia medica* for the medical articles, indexed under the name. A start was made with the year 1900, for convenience sake, as the Index Medicus, old series, suspended publication in April, 1899 and for nearly a year there was no substitute. In 1900 the French publication, *Bibliographia Medica*, started but only lasted three years or until the present Index Medicus was started. So that it will be seen that this investigation extends from January 1, 1900 to January 1, 1916. The year 1916 was not reviewed because this work was started late last summer and it was not considered practical to review a part of a year. Turning to the list of Detroit physicians in Polk's Medical Directory for 1900, each name was checked off in the list of authors in *Bibliographia Medica* for 1900. When one was found in the latter that corresponded to one in the former, the reference page was noted and looked up. Then the title of the article, the journal, the year, the volume and the page were placed opposite the name. The name of every Detroit physician appearing in Polk's for 1900 was checked in the same way in the medical index for 1900. Then the year 1901 was taken and so on down to and including the year 1915. As was mentioned, wherever possible, the A.M.A. Medical Directory was used especially for the later years.

When the lists for the different years were all prepared, checked off and revised, the articles in the various journals were all read, certain points in the article were noted, for example, did the writer have any bibliography at the end of the article, did he report any cases, or did he simply write generalities, or did he rehash some textbook or textbooks? What was his article, good, fair or poor?

While the number of articles reviewed was nearly 1200, the number written during these sixteen years was over 1300. A few articles, about one hundred, were published, or perhaps buried is a better word, in such insignificant journals that they were not available for perusal either in our own library or in the medical stacks of the library at Ann Arbor.

A perusal of the data gained disclosed some interesting figures. Of the 1189 articles reviewed, in only 155 or 13 per cent. of all, did the authors show that the medical literature had been consulted. In 1034 articles, or 87 per cent. of all, the writers neither referred to the medical literature in the body of the article nor did they append any bibliography. Con-

cerning the quality of the article as an addition to medical literature, I have classified them as good, fair and poor. This was purely arbitrary on my part and many articles classified as fair might be considered as poor by another. This is agreed, but I do not believe we would vary much as to the number of articles classified as good. The figures were as follows. Of the 1189 articles 85, or 7 per cent., were good; 911, or 77 per cent., were classified as fair and 193, or 16 per cent., were poor. Certainly a very poor showing for sixteen years! The number of articles written each year varied from twenty-one papers in 1902, to 135 articles written in 1906. I will not weary you with the figures for each year but refer you to the appended tables.

Another angle, from which all these yearly lists were considered, was that of place of publication. The 1189 articles reviewed plus the number that could not be located or 196 equals 1387 articles, the total number written by members of the Detroit profession during the sixteen years reviewed. These 1387 articles were published in 1448 journals or sixty-one of them were published in one or more journals. This duplication will be referred to later on. Of these 1387 places of publication, 332, or 24 per cent., were in journals published in Detroit; 553, or 39 per cent., in journals published in this state or in other state journals; 487, or 35 per cent., in national medical journals and 33, or 2 per cent., in foreign journals. This latter division includes the articles published in Canadian medical journals.

The statistics just given show that our contributions to medical literature during the last sixteen years have lacked both in quality and in quantity. It is not surprising that a good many of us are not known, if not beyond the limits of our city, at least beyond the borders of our state. This will continue to be so until we are awake and do more than we have in the past. We must not think that when we are invited to read a paper before our own or some other county society and we sit down the night before and dash off several pages of platitudes, generalities or rehash several text books upon a chosen subject, we must not think, that we have done our duty to ourselves and our profession and furnished our share of contributions to the medical literature. Not that I would discourage reading papers before county societies or small gatherings of special societies, but do not let your energies rest there. Every medical man should produce every year at least two first class medical papers or monographs

that are worth while. This may seem to be a hardship to a busy medical practitioner who will say that he has no time for experimental or research work. This is no doubt true, but the busy practitioner, and by this term I include the specialists, could confine his energies to reporting some unusual case, some untoward symptoms or some special operation that must be found among his daily cases either in the hospital or in the home. Too often when a suitable basis for a paper does result, the writer is liable to rush into print, as it were, without giving the subject matter the proper careful consideration that he does his other medical work.

In the first place, let us say that you have a proper topic for discussion, for example, a small transverse incision in operating for appendicitis. You have tried this method of opening the abdomen when operating for appendicitis and find that in your hand it facilitates the technic. Do not rush into print immediately after first operation as so many do, thinking to be the first to describe such a wonderful modification of the operative technic. Wait until you have one hundred operations or better two hundred or more. In the meantime you will be able to scan the literature by looking the subject up in the *Index Medicus*, the *Catalogue of the Surgeon-General's Library*, or in the *Cumulative Index of the A.M.A.* You may find that some one else has already tried this same thing years before and abandoned it after a few hundred operations. With all your operations, with all the data gleaned from the medical literature upon abdominal incisions in general, because we will infer you will probably not find your special incision, with the histories of your patients, description of the operation, after care and convalescence, you may now start your paper. If you use proper discretion in the handling of all this material, it will take but a few hours to write your article. I am not trying to advise how to write the paper because I am taking it for granted that the real composition of the essay is known to you. I simply want to advise you how to choose your data so that we may all correct our mistakes and short comings of the past.

Among the papers received, I found one that had a very comprehensive title about a new method of treating typhoid fever, with report of 138 consecutive cases successfully treated during the last ten years. This article was composed of three and one-half pages, one full page of which was taken up with a temperature and respiration chart. You can easily imagine

how fully the subject was treated. Such papers are utterly worthless and might better not have been written. But what a fine subject and what fine material with 138 cases to produce an epoch making monograph. I found so many like this in my search in the literature of the last sixteen years. Another instance was a paper on a new operation for amputation of the cervix. The reporter had done one or at most two of this new operation. Yet he reports it as a very successful operation and drew his conclusions from but one or two operations.

Let us suppose that some one of you has an unusual case to report. By all means do so and try to have your own notes as full as it is possible to make them, a complete history of the patient, supplemented with laboratory findings and in fatal cases with pathological diagnosis both macro and microscopical. The next step is to search the literature carefully for all similar cases and suppose for example you find fifty other cases in the literature. These fifty cases should be reviewed in a general way by you in your paper. The addition of your case makes 51 in the literature and brings the literature of this subject down to date. When the next case of this kind occurs the next reporter will be obliged to make use of your exhaustive article and mention you in connection with his report. Of course all of this takes time and a lot of hard work, but a lot of the data can be turned over to your office assistant who can easily be taught how to look up medical literature and employ her spare moments by this diversion.

Another instance of weakness on our part is in the choice of journal in which to publish our paper. You will remember the figures I read above, nearly two-thirds of the papers written during the last sixteen years have been published in local medical journals. This is of course no way to obtain a wide circle of readers or at least a circle of readers of the best class. If you must publish your article in a local journal, then a good plan is to make an abstract of your article, referring to the journal, year, volume and page and send this abstract to twenty or thirty of the leading national journals with a request that it be published in their abstract department when a chance offers. This abstract need only consist of a few words but it will call attention to your original article in a way that nothing else will. This method of dissemination may also be used wherever your article is published. It is a casting of your literary bread upon the medical waters.

Another reason for having a list of good contributions to the medical literature is that some of you will no doubt be ambitious of joining your special national society. Unless you can furnish a fairly comprehensive bibliography of personal articles, your chance of being asked to join these societies will be slim. In looking over the transactions of the last Congress of Physicians and Surgeons, I consulted the membership lists and found that by actual count only twenty-two members were from Detroit. Deducting names counted twice leaves only twenty men from Detroit that belong to the various special societies that compose the congress. The American Neurological Association, the Association of American Physicians, the American Association of Genito-Urinary Surgeons and the American Society of Tropical Medicine, have no members that hail from Detroit.

In closing I would like to append verbatim an abstract that I read in the *Journal of the American Medical Association* a few weeks ago. (Vid. *Journal A.M.A.*, 1917, LXVIII, 395). This abstract is made of an article, entitled, "Too Many Medical Papers," that appeared in an Italian medical journal, *Il Policlinico*. The advice and council contained in it is most timely and dilates on many important points that I did not.

The scarcity of paper and its increased cost seem to be universal. The *Policlinico of Rome*, in commenting on the fact that many medical journals have suspended and that others have reduced in size, regards the condition as not an unmixed evil. "The most tangible result," it says, "is that the amount of material published is sensibly reduced. This is not a serious evil, as too much has been and is being published. It is not a bad thing for literary production to be restrained, condensed, reducing particulars to inclusive wholes. It is certain that a larger proportion of the medical journals contain too much that is trite, deplorably banal. They accumulate too many useless data, which might be suppressed to great advantage. Many articles have not the slightest reason for existing, and they merely cumber medical literature. Graphomaniacs (this is not a bad word; it would not be out of place if applied to some medical men in this country) abound among physicians; some are graphomaniacs from temperament, others from policy." Presumably the *Policlinico* means here that it is an elegant and ethical form of self-advertising. Farther on: "Regardless of the superficiality of certain arguments, they dilate on them and dilute their

	Year	1900	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910	1911	1912	1913	1914	1915	Totals	%
Number articles referenced	51	60	22	114	108	116	114	140	86	85	77	104	120	100	95	93	77	1448	—
Number articles written	51	60	21	110	101	114	135	85	85	82	73	98	112	98	86	87	74	1387	100
Place of Publication																			
Detroit Journals	37	22	0	34	27	51	38	15	13	19	14	14	14	12	10	7	16	332	24
State Journals	0	12	10	38	45	30	45	50	39	31	42	49	49	42	28	46	28	535	39
National Journals	13	26	10	38	26	32	49	17	29	22	37	45	45	43	42	30	28	487	35
Foreign Journals	1	0	1	0	3	1	3	3	1	1	1	5	4	1	3	4	2	33	2
Published in two or more Journals.	0	0	1	4	7	2	5	1	3	4	4	6	8	2	9	6	3	61	4
Number article reviewed	45	60	19	101	88	108	116	66	67	60	75	92	92	83	72	78	59	1189	100
Références	3	7	4	7	11	9	25	10	5	2	7	10	10	18	17	15	5	155	13
No references	42	53	15	94	77	99	91	56	62	58	68	82	82	65	55	63	54	1034	87
Good paper	0	7	1	5	4	11	11	5	5	8	4	4	5	5	2	9	3	85	7
Fair paper	36	23	10	91	41	69	84	49	61	49	68	83	83	69	66	66	46	911	77
Poor paper	9	30	8	5	43	28	21	12	1	3	3	3	4	9	4	3	10	193	16

personal observations with a flood of already known facts and opinions. Their writings contain very little that is new, and what is new and interesting is padded out and strung along *ad nauseam*. The same work appears first in some first-class journal and then, under other titles and with slight changes, it appears in minor periodicals and it fills up space and wastes time in medical bibliography. We refrain from further description for fear they might have too personal a tinge. We all know that the incontinence (a good word in the original—it is *incontinenza*) of these authors might be checked and corrected." The *Polio-clinico* then begs writers to spare the editorial staff the waste of time and energy required to pass judgment on the unworthy articles, "not to mention the disagreeable task of rejecting such manuscripts, and the load of responsibility it places on the editorial staff." The writer concludes with this advice, which we respectfully pass on: "Abstain from recording the commonplace and let those who have something really interesting to report suppress useless details, long historical introductions and rehashing of textbooks."

DISTURBANCES OF MENOPAUSE AND THEIR RELATION TO BLOOD PRESSURE.

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Women are afflicted with disturbances, caused by either a true menopause or a menopause state which may exist and does exist some times long before menopause period is shown by irregular menses and at times long after menstruation has ceased.

The term menopause does not cover that period in which the sexual life of the individual, whether male or female, has its stormy physical disturbance. The term climacteric, in a sense, covers it pretty well for it is a time when the system undergoes marked changes. This change in a female is not always indicated by a cessation or even a disturbance in the menstruation. Many times we see oversecretions and undersecretions from the ovaries of the female, the testes of the male which cause a marked disturbance of the circulation, of the nervous tone, even of the mental states of the individual.

It is an accepted theory that in the removal of the ovaries, menstruation ceases and the giving of corpora lutea to a marked degree furnishes that secretion which, when the ovaries are removed or cease to function, re-establishes

that mental, nervous and circulatory tone so necessary to a perfect metabolism.

There have been many monographs written upon this subject during the last fifteen years, but one peculiar phase, which is less dealt with in the literature, we would like to bring out from our experience as shown in the cases to be reported. That is the phase of disturbance to blood pressure and the chain of symptoms which accompany it.

Among the many symptoms found with the disturbance of the climacteric are the hot and cold flashes, due to the uncontrolled circulation, insomnia, extreme nervousness, pain in the epigastrium, tingling and burning in the nerve endings and the marked rise in blood pressure in which we are particularly interested.

In any number of cases in which we have seen this increased blood pressure, the elasticity and tone of the artery and vein seem to be affected and the distribution of the circulation is as marked as is the pressure. Only after a careful, differential diagnosis can proper treatment be organized in this class of cases because in one way and another they simulate so many diseases. If the menstruation is not irregular or there is no marked change so that the individual herself is able to discern it and her history does not tell it to you many different tangents may be taken before the patient is relieved. We have the high blood pressure found in the arterio sclerotic cases in which we get an elision of speech, slowing up of the mentality, disturbed reflexes, sharp, shooting, lancinating pains in the extremities, any or all of which symptoms may be found in early paresis, even the hand-writing being affected; and yet any one or all of these symptoms are complained of by individuals suffering at the change period, yet no hardening or thickening of the artery.

It is not the marked, well historied cases of menopause that I am bringing to your notice at this time—it is the tangled, obscure cases, those on which we make our mistakes, and the other fellow, digging them out, wonders how we could have missed them.

It is very necessary that the blood pressure be taken from time to time and the use of the corpora lutea be discontinued, should the pressure fall below normal. We have found the use of the corpus luteum extract very valuable in a natural menopause as in the artificial; by the artificial, I mean the menopause brought on by the removal of the ovaries.

In a number of cases of very high blood pressure, we have found it necessary to give im-

mediate relief by bleeding. In each of these cases, menopause seemed to be the cause of the marked disturbance and in two cases there was a marked edema of the lungs which cleared up immediately following the bleeding. In one case, where a mental disturbance came on suddenly, blood pressure was very high. Following bleeding, the patient slept and upon awakening, her mind was clear and by the use of corpora lutea at times, has been comfortable since.

CASE 1. Farmer's wife, age 50. Had been complaining for some time, been sick about a year, during which time menstruation had been irregular, kidneys had failed to function properly, digestion was disturbed, bowels were constipated, at times a marked diarrhea, complained of a pain in the region of the pylorus and the stomach. On examination, found heart was dilated and a mitral insufficiency; there was a well localized mass near the pyloric end of the stomach and liver. There was a marked edema of the legs and abdomen; urine contained albumin, blood pressure 190. After consultation, it was agreed that the mass in the liver region might be carcinoma; that the symptoms should be treated, but it was feared not much could be done for the patient.

A little later, distress from edema became so great that it was determined to bleed her, a pint and four ounces being taken. The edema left the legs and abdomen, kidneys began to function, pressure dropped to 150 and the mass which had been palpated in the abdomen disappeared. During the next four years there were a number of attacks of dyspnea, followed by dizziness with a general edema, kidneys ceased to function and pressure would be found very high. She was treated symptomatically with forced treatment of corpora lutea. After several days, all the symptoms would clear up and she would get comfortable.

The spring of 1916 found her gradually returning to good health. She did all her work in the house, helped with the fruit, and since then has seemed to be in good general health.

CASE 2. Age 46, hard working woman, thin, very nervous and excitable, bowels badly constipated, dizziness, hot flashes, gas after eating, abdomen bloats, a marked elision of speech, pupils unequal and irregular, slightly choked disc; co-ordination badly disturbed, reflexes greatly exaggerated, disturbance in memory. Wassermann test was negative, urine contained albumin, arteries slightly sclerosed, blood pressure 240. She was bled and in four days, pressure reduced to 190. Corpora lutea was given t i d, hot flashes ceased within a week. Along with this, a luetic treatment was instituted, digestive disturbance reduced, dizziness was relieved, pressure came down to 160, patient became quite comfortable, but the speech and locomotor affections remain about the same.

CASE 3. Age 54, farmer's wife, well-to-do people, always been hard working, healthy woman. Of late complained of dizziness, disturbed digestion, fullness in the head, periods of depression, loss of memory. When seen about 11 o'clock at night was in a badly disturbed, confused state, did not know her immediate family, talk was rambling, complained of a great deal of pain in the head. Family noticed the

unnatural condition of the mother about noon. Pressure was 220; heart negative, pulse rapid, full and bounding, some edema in the chest, face very red. She was relieved of about a pint and a half of blood, or until the pressure came down to 170. Within an hour she became quiet and dropped off to sleep. Next morning she seemed to be as rational as ever. She was given corpora lutea t i d and continued to use them at times when the symptoms would be distressing, and has been quite comfortable since.

CASE 4. Age 38, weight 68 pounds, had been a morphine user for five years. Five years ago had both ovaries removed, since then has suffered excessively from hot and cold flashes, pain in the epigastrium, hot, burning sensation in the skin; has had treatment for morphinism twice, but never entirely off. She had unequal pupils, exaggerated reflexes, loss of co-ordination, speech balled up, history of gastric crisis with a feeling around the waist like a hoop around a barrel. Gave a history of leuetic infection. Wassermann test positive.

Here we have three conditions: Morphinism, leuetic infection and menopause symptoms.

She was placed on treatment for morphinism. At the end of eleven days was off from it. As soon as her physical condition permitted, she was placed on sodium chocacodylate, 3 gr., followed by salversan, and corpora lutea 5 gr. t i d. She gained weight rapidly, so that in three months she weighed 122 pounds and the only symptoms remaining now are the hot flashes and the burning sensations of the skin which are relieved by taking corpora lutea for a few days when symptoms indicate use.

CASE 5. Age 41 years, usual weight 190 pounds; when first seen weighed 150, very nervous, hallucinated at times, full of fears, had a sensation of weight in the abdomen for three years, complained of not being able to walk as well as formerly finding it difficult to pick up her feet, loss of strength in her hands, complained of sharp, shooting pains all over the body, hot and cold flashes, memory affected, a sensation as though everything were hazy and blurred before the eyes. Knee reflexes were lost, pupils unequal, Argyll Robertson sign found, leuetic treatment instigated. Examination showed a large tumor mass in the pelvis, Wassermann test positive. Consultation was called to determine whether operation feasible. Operation showed a large fibroid uterus in which mass tubes and ovaries had been drawn. All were removed. Patient had slow recovery, was mentally disturbed for ten days or two weeks. Was placed on corpora lutea t i d; mental symptoms cleared, complained less of the menopause symptoms, leuetic treatment was continued. Within four months had gained from 112 to 175 pounds. Her gait is still affected, eyes improved. In this case the history of the eye disturbance is very interesting. A partially choked disc appeared in the right eye and then in the left. Under treatment, the eyes cleared up, much to the surprise of the oculist, a man of long experience, who said the eye sight would be completely lost.

CASE 6. Age 60 years. Menopause began at 50, has had more or less disturbance since, complains of pains in different parts of the body, gets choking spells, short of breath, has fears, at times unable to go to bed at night, sleeps in chair, has lost some

weight, gas after eating, bowels constipated, hot and cold flashes.

Findings.—Sways in Romberg's position; co-ordination good, pupils active, knee reflexes exaggerated; pulse 108, pressure 210. No history of lues, Wassermann test negative, urine negative, blood count negative, stomach analysis showed a hypochlorhydria; patient treated with dilute hydrochloric, corpora lutea t i d. Within two weeks pressure was down to 155, patient sleeping fairly well, eating better and feeling fairly comfortable.

CASE 7. At the age of 44 began having headaches, fullness in the head, irregular menstruation, hot and cold flashes, pains all over the body, memory affected, some speech elision, blood pressure 230. Had an attack of dyspnea with marked edema of the lungs and a slight stroke affecting the right side and the speech. She was bled about a pint and a half and was immediately relieved. Was later placed on corpora lutea t i d which she has learned to take at times when symptoms are distressing. Pressure seldom goes above 170.

CASE 8. Age 36. School teacher, fairly good health except became very short of breath, easily tired and very nervous. On examination, pressure was found to be 225; a large mass palpated in the right side of the pelvis. These were the only findings. Operation was made, large cyst removed on the right side which included tube and ovary, left tube and ovary pathological, removed. No history of infection. Good recovery was made. She continued to have menopause symptoms, placed on corpora lutea, pressure came down to 140, symptoms disappeared. In this case, the cause of the pressure was very obscure, but it is safe to say that it was one of those cases of a menopause state, as the operative procedure showed that the ovaries had ceased to function and treatment that followed gave relief.

THE RELATION OF THE PHYSICIAN TO THE COMPENSATION ACT.*

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Practice of medicine and surgery has experienced many changes in the past few years and doubtless will make many more in the near future. With the passing of the old family physician, has come the era of specialization and in this change the public have both gained and lost. The tendency of the times politically is socialistic and this influence is making itself felt in the practice of our profession. The workings of the Workmen's compensation law show that the state is more and more becoming the guardian of the individual and is assuming more or less of a protectorate over him. Where once the employe was supposed not only to stand the expense of any sickness or injury which might befall him, as well as losing his

wages during the time of his disability, the laws of most states have now provided that in case of accident, the employer shall furnish or cause to be furnished such surgical attendance and hospital care as may be necessary, for a stated period, and that the employe shall also receive a percentage of his wages during his disability. Certain states also require a system of compulsory health insurance, planned somewhat after the health insurance now in effect in most of the countries of Europe. In the State of Michigan there is no compulsory health insurance, but an optional law has been provided whereby an employer may, if he so chooses come under the protection and the workings of the Compensation act. This act is compulsory upon municipalities, but is optional with corporations, firms or individuals employing labor. Before this act was passed the employer had three points of defense: (1st) Contributory negligence, (2nd) The fellow-servant rule, (3rd) Assumed risk. Under the law as it now stands, all these defenses have been removed and the employe may bring legal action against an employer to any extent that he sees fit, provided this employer is not protected by previously enrolling himself under the Compensation Act. This law beside setting certain special percentages of compensation for certain injuries or disabilities, provides that the injured employe shall receive hospital and surgical attention for twenty-one days next following the date of the injury and that he shall receive half of his average wages after 14 days of his disability so long as he is disabled, provided, that if he is laid up eight weeks or longer he will also receive compensation at the same rate for the first two weeks as well. Immediately upon the taking effect of this law in September, 1913, numerous insurance companies began to provide insurance for the employer, based usually upon the hazard of the occupation the manufacturer was engaged in, and rated as to premium at so many cents per \$100 of payroll. This plan of course relieves the employer of all responsibility financially and otherwise in regard to the accidents, provided he sees to it that the injured employe is placed in the hands of competent medical and surgical care. Right at this point I wish to state that the Industrial Board has determined that the employer may choose what doctor shall have the case, provided his choice is a reputable and competent physician. If the injured wishes other advice or consultation, he is at liberty to call it, but at his own expense.

As might be expected, transferring the re-

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sponsibility in case of injury from the local employer to a foreign insurance corporation, which has no interest except that of fat dividends at the end of the year, necessarily gives rise to more or less friction and controversy. First, they are always eager to cut the injured man off with as little surgical care as possible and if possible, get him back to work within fourteen days to avoid paying compensation. On the other hand they are inclined to scrutinize, hypercritically, all bills rendered for service in his behalf, because every dollar saved, means dollars of dividends for the stockholders of the insurance company.

With conditions as they are, I think it well that each and every physician should have definite knowledge of what constitutes his legal rights in these cases. Many of the points that were disputed in the first months of the existence of the Compensation law, have not only been passed upon by the Compensation Board and placed on record, but have gone to the Supreme Court and permanently established. One of the points that the Insurance Companies try to make with the doctors is in regard to what constitutes the 21 days of treatment. The law says that "The employer shall furnish or cause to be furnished, competent professional care and hospital services, if needed, for 21 days" and the Compensation Board have ruled that in the working of the law, the term "accident" and the term "injury" are not necessarily synonymous, inasmuch as at the time of an accident, it may not develop that an employe has received any injury, but the Board holds that even after so long a time as six months or more if the progress of the case shows that injury results, the employe is entitled to the 21 days treatment notwithstanding. Doubtless all of you, as I have, have had bills returned with the statement that charges were made after the 21 days legal limit, dating the same from the time of the accident, but the Board holds and this is a matter which they cannot evade, that the 21 days shall date from the time when the employer first furnishes or causes to be furnished, professional aid. It is the same proposition as is met with in all commercial lines, the insurance companies will try by every means possible, to cut the doctor down to the last penny on his bill. I do not mean to say that this occurs with every company or in every case with any company, but it certainly is common. It therefore stands us well in hand to know what our rights are and stand out for them absolutely without compromising, only being careful that we are right in the be-

ginning. Each company is bonded by law to pay every reasonable legal bill, for only by so doing can they satisfy the requirements of the Board at Lansing, the Board having the whip-hand over them to the extent of securities to the amount of \$50,000, pledged to the State of Michigan in good faith to operate as the law requires, and doctors' and hospital bills and compensation are three points that must be taken care of to the satisfaction of the Board.

Many insurance companies try to make some contract with a local physician at reduced fees for taking care of the risks, which they may carry in any given locality, but in spite of this, the employer is at perfect liberty to employ any physician he may choose and these bills, so long as they are reasonable and conform to the usual charges made in that vicinity, must be paid without reduction.

Furthermore when special services, such as consultation, major surgical operations, X-rays or the expert services of the oculist are required, it is not necessary to get the consent of anyone before employing them. All that is required is to be able to show that the services are reasonable and necessary.

Many very grave responsibilities lie with the physician in charge, under the operation of this law. All concerned have to be governed very largely upon the physician's recommendations and judgment and one should be very careful that all opinions passed and all judgments rendered should be as nearly the exact truth as he is able to determine; in that way only will the ends of justice be fully served. It is at times very difficult to tell whether a man is malignering or not. In cases of alleged rupture, it may be impossible to state definitely whether disability in this regard existed previous to a certain alleged strain or not. Again in cases of strain in the back, it may be impossible to state otherwise than an opinion. In the former case where rupture is claimed, if it exists, the Compensation Board have been very liberal in their rulings and require that where the patient demands it, an operation with its attendant expense, must be furnished. Another peculiar point is that an employe who has been injured can recover damages if he is not restored to such an extent that he can perform the same work that he was doing when he was injured, even though he may be able and actually does take up some other occupation which carries with it a larger remuneration. It stands every employer well in hand to have his employes pass a thorough physical examination before they enter his employ, in order that old patho-

logical conditions for which he is in no way to blame are not pawned off upon him or the insurance company. This practice will also increase shop efficiency.

So far the Compensation Board have made no allowance in settling compensations for the fact that the man may not have been a good physical risk when employed, or that he had syphilis, sclerosed arteries, or tuberculosis or any other defect, holding it to be a fact that everyone has something the matter with him and that the ends of the law would be defeated if allowance were made for these cases. In my opinion the time is close at hand when every employer of labor must be safe-guarded by such previous examinations.

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.

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The diagnosis of incipient pulmonary tuberculosis is not an easy matter. However, there are few conditions in which the early recognition of the process is so important, and there are few maladies in which the physician may so definitely save the life of his patient. Early diagnosis is no mystery, but is merely the reward of eternal suspicion and habits of carefulness on the part of the family physician, to whom these cases first apply for diagnosis. Upon the general practitioner rests the responsibility of diagnosis in the majority of cases, and for this reason he should be ever on the alert. As Sir William Osler has so tersely said, "The general practitioner is the man behind the gun in the combat of tuberculosis."

The question of early diagnosis cannot be answered by setting aside one or two constitutional symptoms and one or two physical signs and saying that these together in every case make up the symptom complex necessary for the diagnosis of clinical tuberculosis. A negative physical examination is not conclusive, and a prolonged observation of the general health is often necessary. There are some twenty-five or thirty symptoms which may accompany early tuberculosis, and it is characteristic of these symptoms that they are inconstant and indefinite. We do not find any single symptom, or any particular group of symptoms present under all circumstances.

The early diagnosis of pulmonary tuberculosis may, in certain instances, be made from

the physical signs alone, or from the symptoms alone. However, in order to arrive at an accurate conclusion it is usually necessary to weigh all the available clinical data; the history, the symptoms and the evidence furnished by a careful chest examination.

I wish simply to describe the basis for diagnosis which has been found to be of practical usefulness, and will omit unnecessary details; which are often more confusing than helpful.

First, in logical sequence, as well as in importance perhaps, is the history. Of special importance is the establishment of a definite history of exposure to infection, especially if that exposure has been intimate or prolonged, and *if it occurred during childhood*. The history of previous diseases should be gone into very carefully, and many cases of grippe and pneumonia will plainly spell tuberculosis when the details of the case are brought out by careful questioning. Protracted convalescence from grippe, bronchitis, whooping cough, measles, pneumonia and typhoid are suspicious, and should evoke further inquiry. A past history of enlarged cervical glands, pleurisy, either dry or with effusion, and fistula in ano can almost always be assumed to have been tuberculous. The history is very important and should be gone into in detail.

Symptoms are a most important factor in the diagnosis of active tuberculosis. Lawrason Brown says that "symptoms in the early diagnosis of tuberculosis are a more accurate guide to the presence of activity than physical signs; that symptoms without physical signs demand treatment, while physical signs without symptoms require only careful watching."

I wish to discuss briefly some of the more important and frequent symptoms occurring in early tuberculosis. I shall omit mention of the less important symptoms, which nevertheless are of some value as corroborative proof of the presence of the disease.

COUGH.

This is very frequently the first manifestation of the disease noticed by the patient, and is so invariably present in tuberculosis that one cannot think of the latter without the former. In most cases cough is an initial symptom, but may be so slight or so overshadowed by other symptoms as to escape attention.

EXPECTORATION.

Another more or less constant feature of pulmonary tuberculosis is expectoration. As with cough, one encounters marked differences

in this symptom, both in character and amount. In incipient cases it may be scanty, or absent altogether. The question of whether bacillary findings in the sputum are absolutely necessary before making a diagnosis is an hackneyed one. It is now the consensus of opinion that it is most frequently possible to make a diagnosis before tubercle bacilli appear in the sputum, and any physician who defers diagnosis on account of the absence of the bacillus, assumes a grave responsibility. Bacilli can appear in the sputum only after caseation and breaking down of a tubercle, and its discharge into a bronchus. Hence, when bacilli do appear, the case is, strictly speaking, no longer incipient. When possible, the specimen for examination should be the sputum raised in the morning. One should not be satisfied with one negative sputum examination. In suspicious cases, at least three different specimens should be examined on as many different days, before assuming that the sputum is really negative.

HEMOPTYSIS.

What I mean by hemoptysis is bleeding from below the glottis, without regard to the amount. Hemoptysis, in the absence of other causes, among all the symptoms, is the one of greatest significance. It is the initial symptom in about 12 per cent. of cases, and 60 to 75 per cent. of tuberculous subjects exhibit this symptom at some time during the course of the disease. It is now pretty generally agreed, that the occurrence of hemoptysis which cannot definitely be attributed to any other cause, should be regarded as proof of the existence of active tuberculosis.

TEMPERATURE AND PULSE.

An increase in the body temperature is probably one of the earliest indications of incipient tuberculosis, and is of great value, especially if other suspicious symptoms are present. Hence, a careful record of the temperature should be kept in every case. In early cases, the fever may range from 99.5 to 100.5 deg. reaching its maximum usually in the afternoon at about 4 p. m. This is not always the case, however; the rise occurring sometimes as early as noon, or as late as 9 p. m. For this reason the temperature should be recorded at least every three hours. The pulse is very frequently elevated, and is of low tension. A persistently rapid morning pulse is of some diagnostic value.

One of the very earliest symptoms of this disease is *loss of weight*. It is so early a fea-

ture that in some incipient cases it is the first to attract attention, and may even proceed with such rapidity as to be in striking contrast to the small amount of lung involvement. It should be kept in mind that tuberculosis is one of the most frequent causes of loss of weight.

HOARSENESS AND CHEST PAINS.

Hoarseness is often found as one of the symptoms of early tuberculosis. We all know how common it is in the advanced stages. I feel that we should pay more attention to the aching over the shoulders and over the upper portions of the lungs, and to chest pains, for it is remarkable the number of patients who complain of these pains and aches early in the infection.

PLEURISY.

Pleurisy with effusion has for years been considered as always tuberculous in origin by many; and of late the feeling seems to be growing that dry pleurisy should also be classed as tuberculous, until proved otherwise.

The study and correct interpretation of the physical signs of incipient tuberculosis demand our best thought. The signs are few, and often so indistinct as to require great pains for their detection. In view of these facts, it seems worth while to insist upon the importance of the following simple procedures during examination, the value of which the writer can vouch for from personal experience. The patient should be stripped to the bare skin, and down to the waist. The examining room should be quiet and the patient should be placed in a comfortable sitting position on a stool, with all muscles relaxed. In doubtful cases, two or three examinations on different days may be desirable. In many frank cases of pulmonary tuberculosis, physical signs are entirely absent, and this does not seem strange when we stop to consider that light changes which occur more than three-fourths inch below the surface of the lungs cannot be detected by physical examination.

In the examination of the lungs, the usual methods of inspection, palpation, percussion and auscultation are of course routine, and are generally in themselves sufficient.

INSPECTION.

In incipient cases the chest usually shows no marked changes from the normal, the phthisical or flattened thorax seldom being seen in this stage of the disease, although it is common in the advanced stages. Often the clavicle on the affected side stands out prom-

inently and often slight drooping of one shoulder may be noted. Lagging of one side during respiration may be seen early, and limited expansion may be present. A unilateral drawing in of the apex of the lung is especially significant.

PALPATION.

Under this heading the only point which I wish to mention is *muscle spasm*. Pottenger has called attention to the fact that with disease of the upper part of the lung the overlying muscles of the neck and thorax may be felt, best with the lightest palpation, to be more rigid and tense than those of the sound side. This sign may be present and well marked, early in the infection, and may in some cases be the only physical evidence of the presence of the disease.

PERCUSSION.

The amount of information obtained by percussion stands in direct ratio to the amount of change produced by the disease. If slightly impaired resonance can be made out at one apex, it furnishes information of immense significance. The careful determination of the height of the two apices is of value. If there is incipient tuberculosis of one apex, this may generally be demonstrated to be appreciably, although but slightly lower than the opposite apex. In determining slight shades of dullness, very light percussion should be used, and one must be keen to perceive slight differences in the pitch of the percussion note at the two apices, and must compare over and over again, if need be, the resonance of corresponding areas.

AUSCULTATION.

It is from auscultation that we obtain our most accurate information. Although every portion of the lung should be examined with the stethoscope, certain areas should be examined with special care. In the order of their importance they are the apices above the clavicle, the apices behind in the supra scapular fossae, the interscapular spaces and the first intercostal spaces. In early tuberculosis the breath sounds may show no changes. In many cases the first change is a roughening of inspiration with prolonged expiration. With progress of the disease, the breath sounds become more distinctly roughened and harsh until they finally become broncho-vesicular in type. Occasionally the breath sounds may be faint, but yet retain their normal quality.

Among the early physical signs, the *rale* is

the most definite. In 70 per cent. of incipient cases rales are latent, that is, are elicited only on coughing. Unless the patient is made to cough during the examination, these rales may readily be overlooked. Rales are best elicited by an expiration, immediately followed by a cough and a deep inspiration. It is often necessary to explain to the patient, best by example, how to cough. If, at an apex, a few rales can be constantly demonstrated, there can hardly be any doubt as to the presence of tuberculosis (Brown).

In order to make this paper as complete as possible, brief mention will be made of the more important accessory methods of diagnosis.

X-RAY.

The evidence furnished by the X-ray is very valuable as corroborative proof of the existence of tuberculosis. However, it does not differentiate an active from an inactive lesion except in the hands of a few experts, and for this reason a diagnosis of active tuberculosis should not be made from positive X-ray findings, in the absence of symptoms and physical signs. Early and slight lesions are detected much more readily by means of the X-ray plate than by the fluoroscope. A single X-ray plate is of little value; stereoscopic plates should always be made.

Of the various tuberculin tests, the *Von Pirquet* is the test of choice in children, especially those under five years of age, in which a positive result usually indicates tuberculous infection. The younger the child, the more certain is the result. In adults the test is of no practical value, as about 90 per cent. give positive reactions. This test has no contraindication in children.

THE CALMETTE TEST.

While generally condemned, this test is nevertheless being used, and is giving good results in the hands of many clinicians. The advantages of this test are its simplicity and ease of application, its rapidity and its applicability in febrile case, in which the subcutaneous method cannot be used. The Calmette test is contraindicated in the presence of ocular tuberculosis or a history of tuberculous keratitis or phlyctenular conjunctivitis. It should never be used a second time. Many authorities regard any form of conjunctivitis as a contraindication. The test is a very delicate one, and in suspicious cases, a positive reaction is fairly certain proof of the presence of active tuberculosis.

THE SUBCUTANEOUS TEST.

This is very useful and valuable, but is dangerous if improperly used. For this reason, it should be resorted to only by those who are skilled in its use.

In conclusion, I wish to emphasize the following points:

1. In the majority of cases, an accurate diagnosis can be made only by a correlation of the data furnished by the history, symptoms and physical examination combined.
2. Symptoms are a better and more accurate guide to activity than physical tissue.
3. Prolonged observation of a case is often

necessary before a positive diagnosis can be made.

4. In suspicious cases an every three hour temperature and pulse record should be kept for several days.

5. Persistent rales at an apex mean tuberculosis almost invariably.

6. One should not wait for a positive sputum before making a diagnosis of tuberculosis.

7. Tuberculin tests are often very helpful, but should be used only in suspicious cases, in which a diagnosis cannot be made by other means.

Dating of Biologic Products.—William H. Park, Director, Bureau of Laboratories, Department of Health, City of New York, endorses the recently adopted requirements of the Council on Pharmacy and Chemistry that biologic products to be acceptable for New and Nonofficial Remedies must bear a statement of their date of manufacture. He believes that these requirements might well be made more specific and stringent. The rules of the New York Health Department governing the distribution of biologic products are: 1. The label on all bacterial vaccines must state the date the suspensions are made, standardized and killed. 2. The label on antitoxins shall give the date when the preparation was last tested. 4. The label on vaccine virus shall have the date when the virus was last tested. Dr. Park states that there is no intention of extending the potency date of bacterial vaccines (four months) or of serums (nine months) other than the antitoxins until there are very specific data on which to act. For vaccine virus 100 per cent. of "takes" is demanded. (*Jour. A.M.A.*, May 12, 1917, p. 1428.)

Salvarsan in Tabes with Optic Atrophy.—Some assert that salvarsan occasionally produces optic atrophy; others with extensive experience believe that it has no injurious effect on the eye. If given at all, it should be administered early in the disease. (*Jour. A.M.A.*, May 12, 1917, p. 1430.)

K-Y Lubricating Jelly.—The composition of this proprietary has not been divulged. Probably a simple tragacanth jelly will produce the same effects as this proprietary preparation. At the German Hospital, Philadelphia, a jelly made from tragacanth, 3 gm., glycerin, 25 c.c., phenol, 1.5 gm., with water to make 300 c.c. has been used for years. (*Jour. A.M.A.*, May 12, 1917, p. 1430.)

More Misbranded Nostrums.—The following "patent" medicines have been found to be marketed in contravention of the requirements of the U. S.

Food and Drug Act, chiefly because the medical claims were found untrue: Whitehall's Megrimine, capsules containing acetanilid, caffeine and salol (in one instance also capsules containing antipyrine and capsium). Brown's Blood Treatment, a liquid containing mercury and iodid. Classe's Great Penetrating Liniment, an alcoholic solution of ammonia, chloroform, opium, camphor, oil of sassafras, oil of origanum and a thujone-containing oil. Brown's "935" Injection (Formerly H. W.), a dilute solution of acetate and sulphate of zinc. (*Jour. A.M.A.*, May 12, 1917, p. 1427-8).

Biologic Therapy in the War.—According to G. C. McCoy, Director Hygienic Laboratory, U. S. Public Health Service, there are five biologic products—vaccine virus, diphtheria antitoxin, tetanus antitoxin, antimeningococcus serum, and antityphoid vaccine—which may be regarded as indispensable in connection with conditions which prevail when large bodies of men are brought together. The firms manufacturing these products can, if need be, meet the demands of our own army and civilian population as well as those of our allies. McCoy believes that with the good sanitary conditions that may be expected to prevail in our concentration camps, the need for vaccine agents not thoroughly tried out, such as antidysentery serum, antipneumococcus serum, and vaccines against dysentery, cholera and epidemic meningitis, should not be extensive with the possible exception of the meningococcus vaccine. (*Jour. A.M.A.*, May 12, 1917, p. 1413.)

Citric Acid and Citrates.—Citric acid and the alkali citrates, potassium citrate and sodium citrate, are oxidized in the body with formation of carbonates and hence tend to increase the alkalinity of the blood. Citric acid and the alkali citrates tend to render the urine less acid and, in large doses, render it alkaline (*Jour. A.M.A.*, April 21, 1917, p. 1206).

TRANSACTIONS

OF THE

Clinical Society of the University of Michigan

Stated Meeting, April 7, 1917

The President, CARL D. CAMP, M.D., in the Chair
Reported by REUBEN PETERSON, M.D., Secretary

REPORT OF A CASE OF FULL TERM ECTOPIC GESTATION RETAINED EIGHTEEN YEARS. OPERA- TION AND RECOVERY.

REUBEN PETERSON, M.D.

(From the Obstetric and Gynecologic Clinic, University Hospital,
Ann Arbor, Michigan.)

The following case, because of its extreme rarity, has seemed to me worth recording:

Mrs. L. W., aged 46, married at the age of 23, entered the Clinic March 19, 1917. There is nothing of interest in her family or personal history. Her menstruation, which began at the age of 14, was of the four weeks type and has been normal. About a year ago her menstrual periods became irregular, her last period being in December.

So far as the history is concerned, interest centers in the present trouble. The patient comes to the Hospital for an abdominal tumor which has existed for eighteen years. Five years after marriage there was cessation of menstruation, the usual morning sickness and enlargement of the breast. There was a gradual increase in the size of the abdomen until at the ninth month she was as large as a woman at term. She felt life at the fifth month but does not remember at what time movement ceased. She thought she was pregnant but never had any labor pains. Shortly after the cessation of menstruation for nine months, she began to flow regularly again. She remained the same size, that is, the size of a woman at term, for two years, then gradually became smaller. For the past six years her abdomen has been about the size it was when she entered the Hospital. During the past year she has not been feeling well and has lost ten or fifteen pounds.

Examination showed an abdominal enlargement extending from the pubes to the umbilicus.

The tumor rose rather abruptly from the pubes, the highest point being half way between this point and the umbilicus. The growth was symmetrical, smooth, somewhat tender and distinctly fluctuating. It was fixed and apparently quite densely adherent to the parietal peritoneum.

Vaginal examination showed the cervix to be somewhat back in the pelvis and to the right. Posterior to the cervix could be felt an irregular, tender mass about the size of a small hen's egg apparently attached to the tumor which could be made out as a cystic mass by palpation through the culdesac. It was impossible to palpate the appendages.

Unfortunately I examined the patient before a careful history had been taken and only ascertained that she had had the tumor for eighteen years. Because of this long duration, the cystic mass, arising from the pelvis and unconnected with the uterus was thought to be a parovarian cyst. However, just before the incision was made, the assistant informed me that when the tumor appeared eighteen years before, the patient thought she was pregnant but never had had her baby, although the tumor persisted. It was then remarked that in all probability we were dealing with an ectopic pregnancy but unfortunately the tentative diagnosis was made too late to X-ray the tumor, as the results of such an examination would have proved most interesting.

Upon cutting through the abdominal wall, the fluctuating sac was found densely adherent to the parietal peritoneum, omentum and portions of the intestine. These adhesions were exceptionally dense, much more so than in the case of the ordinary inflammatory neoplasm. A normal ovary was attached to the cyst wall and the tube could be traced over the surface of the sac, showing that it was a tubular and not

an ovarian pregnancy. During the enucleation of the sac the latter was nicked in one portion, giving exit to an oily fluid of about the consistency and color of pea soup. The nodule, felt through the vagina was separated from the cyst and removed later. Considerable hemorrhage resulted from the enucleation of the sac on account of the dense adhesions and the patient was quite shocked at the completion of the operation. However, she soon rallied and has made a good recovery.

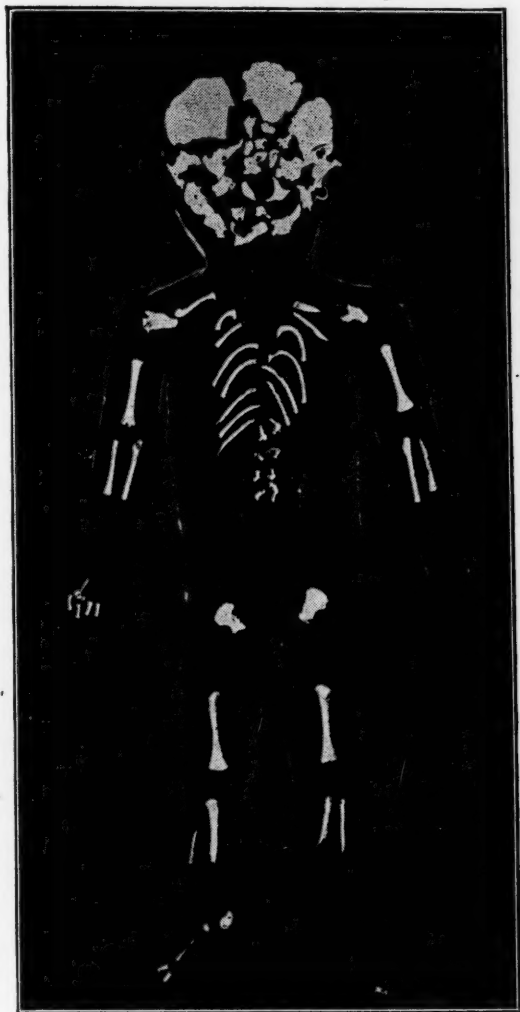


Fig. 1. Photograph of the bones of a full term fetus retained 18 years. Bones identified and arranged in their proper positions.

When the sac was cut open it was found to contain the greater portion of a fetal skeleton. Dr. Sherrick has taken considerable pains to arrange the bones in their proper positions upon this black velvet in order that they may show better. (Fig. 1.) Professor McCotter has gone over them carefully so as to identify them and see that they were arranged correctly. In his opinion the bones are from a nearly if not quite a full term fetus.

The nodule, removed separately, turns out to be a portion of the calcified cerebellum. This portion illustrates what happens in certain cases of retained ectopic gestation where the fetus is beyond the fourth or fifth month, that is, the deposition of lime salts in the fetus and the formation of a lithopedion. In other cases, the fluid in the sac is absorbed, the membranes hug the fetus from which all fluid is absorbed, giving rise to a fetal mummy. Again, the fetal mass may be changed into a kind of soap—saponification. Or, finally, as in this case, the soft parts of the fetus are absorbed, the bones becoming disjointed, "skeletonization" of the fetus resulting.

The literature furnishes many examples of what may happen when an ectopic pregnancy goes to full term, the fetus dying after fatty degeneration occurs in the placenta. Formerly, these cases were only discovered at autopsy for the patients were never operated upon. Now, the condition is usually recognized prior to the death of the fetus, and both mother and child saved by a timely operation.

I have only had time to glance through the literature but I found the records of one case, a lithopedion, where the fetus was retained fifty-five years. In many cases the sac becomes infected and after a longer or shorter time the fetal bones find their way out externally through the intestines, vagina or bladder. In this particular case suppuration did not occur, else undoubtedly the fetal bones would have been discharged, instead of remaining in the sac.

REPORT OF A CASE OF VISCERAL LUES.

UDO J. WILE, M.D.

(From the Clinic of Dermatology and Syphilology, University Hospital, Ann Arbor, Michigan.)

The case which we have to show tonight is perhaps one better spoken of as a suspected case of visceral syphilis, because we have no more than presumptive evidence that the man has visceral syphilis.

This patient, a man of 55 years of age, consulted the out-patient department of Medical Clinic some three or four weeks ago complaining of a long history of gastric disorder, frequent attacks of biliousness, sour stomach, and within the last year or two, of a progressive emaciation.

The physical examination as carried out at that time by Dr. Marshall, showed a man who might well lead to the suspicion of a neoplasm. Without being emaciated, he was decidedly

cachectic in appearance. He had the peculiar lusterless condition of the hair which goes with malignant disease, and the examination at that time with regard to his gastrointestinal tract revealed a mass in the fundus of the stomach which was tender to palpation and which showed itself in the X-ray picture as a decidedly definite functional gap in the stomach similar to that which one gets with gastric carcinoma. In the course of his examination it was revealed that he had had syphilis some fifteen years ago. The gastric disorder started in 1898. So in a man who has had symptoms of chronic dyspepsia for a long period of time there is a gradual onset of pain, of a mass in the stomach, of a slight degree of emaciation and rather a marked degree of cachexia. Obviously this is the picture of a carcinoma. On the other hand, we know that he had syphilis fifteen years ago and that he has still a ++++ Wassermann on the blood.

The question arose as to whether he might have, instead of a gastric carcinoma, a gastric syphilis, and that brings us to the discussion of syphilis of the stomach itself. I may say that there is no clinical gastropathy which may not be simulated by syphilis, and conversely, there is no syphilitic gastropathy which has a typical clinical picture characteristic of syphilis. Thus, we recognize syphilitic round ulcer with exactly the same clinical picture as the ordinary gastric ulcer. There are cases of gastric gumma which are identical in their onset, clinical course and aspects with gastric carcinoma. If either of these two processes occur in or about the pylorus, one has the picture then of stenosis and contraction exactly as one can have from the healing of a pyloric ulcer, or from a pyloric cancer. A third form of gastric syphilis is recognized as a diffuse sclerosing process which gives rise to hourglass constriction by cicatrization in the mucosa and the muscularis of the stomach itself.

With this short introduction, it is obvious that it is impossible to diagnose gastric syphilis except on presumptive evidence, or on pathologic examination either at the operation or at the postmortem. And all of the cases of gastric syphilis which have been recognized and will stand the test of a careful scrutiny are those in which the diagnosis has been made either at the postmortem or at operation, usually for suspected carcinoma or ulcer. There are, however, a large number of cases in which the evidence of a gastric syphilis is presumptive and in which all of the symptoms disappear so completely and with such a remarkable

influence upon the general and local condition that one is forced to believe that they are cases of syphilis of the gastric mucosa or submucosa. We have had in this Clinic such cases and they have been made the subject of a great deal of study.

In Dr. Hewlett's clinic two years ago we had a patient in the last stages of what was apparently gastric carcinoma. He had the most severe degree of emaciation, anemia and cachexia with a large fist-sized mass in the epigastrium which from the X-ray picture was attached to the gastric wall. The man was in extremis when he came into the Hospital. In the routine examination it was found that he had a ++++ Wassermann reaction on his blood, and it seemed at least possible that he might have instead of a large neoplasm of a malignant type, one of the granulomatous type. Simply on this chance, he was transferred and treatment instituted, and he recovered completely within two or three months with complete disappearance of the tumor mass and resumption of the normal function of the stomach and restitution to complete health.

Now, such a case as this, we have before us tonight. This man's trouble became worse about a year ago. He had lost some ten pounds in weight within the last few weeks before his entrance. He had very severe pains in his stomach and the history of what might have been any form of chronic gastric disease, particularly, however, gastric neoplasm. The X-ray report I should like to read in brief. The first report showed the characteristics of a malignant defect.

"Stomach fills fairly normally, though it is narrow. There is no primary segmentation. Apparently there is a defect in the cardiac end. The greater curvature cannot be modified by manipulation but is not spastic, and is somewhat irregular. Pylorus and cap are not at all seen. This defect has all the characteristics of a malignant defect."

The patient was placed upon specific treatment and within two or three weeks he has changed very materially so far as the general condition is concerned. He has gained fourteen pounds and feels very much relieved. The pain is markedly decreased. The spasticity of the abdominal muscles is decidedly less but one cannot feel a definite mass in the stomach. However, we have never been able to feel a mass. The second X-ray report says that the comparison of the two plates leaves the operator in doubt as to whether the condition has or has not progressed

The question as to whether or not this man has gastric carcinoma or gastric lues, I do not believe is settled at all by the mere gain in weight and in general condition as the result of his specific treatment. If he has a gastric carcinoma and constitutional syphilis, then he will improve insofar as the specific infection is concerned, and a temporary gain in weight might not be unexpected at all. One must always consider too, that gastric carcinoma not infrequently occurs on the bases of previous syphilitic ulcers and in the scars of such, or indeed, a large gumma through its becoming necrotic, could easily become malignant, so that one may have both conditions present. I do not think that the temporary improvement can be regarded as anything more than presumptive evidence that the neoplasm that he has is a granuloma rather than a cancer neoplasm. If he has a lues and a carcinoma, the lues is not only in the stomach, but it is all over, in the bone marrow, spleen, etc., and one would expect that he would be in a worse condition with both diseases than he would be with only one, and if he were relieved from one condition he should improve materially. The case is one which will be proven only with the lapse of time, and if this man has a gastric gumma, he should show marked improvement, in fact a total disappearance of practically all the radiographic findings. If these disappear, then I think that in association with all of the other evidence, one would be justified in saying that this is probably a case of gastric lues. On the other hand, if he improves up to this point and the neoplasm remains as a definite mass which can be seen, then, of course, the prognosis is not materially benefited by his treatment, and the other diagnosis will stand.

Three points I think are to be emphasized in the study of the syphilitic gastropathies: First, that there is nothing at all characteristic of their picture. There is nothing pathognomonic of their picture. The positive Wassermann cannot be regarded as anything more than presumptive evidence. A patient may have both diseases.

The second point to be emphasized is that carcinoma and lues of all viscera stand in a very distinct relation one to the other, namely, that malignant degeneration is particularly likely to take place in old syphilitic strictures and recent syphilitic ulcers.

The third point of interest is that improvement, unless it be accompanied by *restitutio ad integrum*, must be taken only as more presumptive of the specific nature of the disease.

DISCUSSION.

DR. Q. O. GILBERT: I remember well the one case about which Dr. Wile spoke. At that time, as I remember, we were unable to differentiate at all between syphilis and carcinoma and he was given treatment because the affection was inoperable if it was carcinoma and there was a reasonable supposition that it might be syphilis.

Two years ago I had the privilege of performing the autopsy on a man who died after two days of violent paroxysms of general paresis. At autopsy the immediate cause of death was found to be a diffuse hemorrhage into the stomach and the gross finding was seven ulcers in the stomach. One of them was perforated through so that I could stick my small finger through the hole. This had a very hard rounded edge and it was walled off by the omentum. There was no obstruction of the pylorus. The other ulcers were all hard, indurated and definitely circumscribed, somewhat different from the ulcers which I have seen in ordinary peptic ulcer cases. I would like to ask Dr. Wile if the ulcers in the cases of lues have the characteristics of ordinary syphilitic skin ulcers, because in this case the ulcers certainly had the appearance of tertiary skin ulcers rather than ordinary peptic ulcers.

DR. MAX PEET: I would like to ask Dr. Wile how he would distinguish between a carcinoma and syphilitic granuloma upon opening the stomach.

DR. WILE: I am very glad that Dr. Gilbert brought up his point. There are two distinct types of ulcer, one which simulates simple peptic ulcer, and then there are multiple ulcerative gummata which give rise to multiple syphilitic ulcers of the stomach corresponding to the nodular ulcerative syphilids of the skin. Those cases are so rare that Dr. Gilbert's case should be described if it has not already been put into the literature. The simple round ulcers are due to syphilitic endarteritis. Many of the cases have almost ruptured without a peritonitis due to the fact that the omentum has glued itself to the peritoneum. The case which Dr. Gilbert describes is one of the very few cases of the very characteristic multiple syphilitic ulcers. The symptoms of such cases are usually those of chronic catarrhal gastritis with more or less hemorrhage.

DR. GILBERT: This patient sat around in a psychopathic institution. He was very depressed and complained all the time. The sister who had seen him for a number of years said that at times he had very marked gastric disturbances of a dyspeptic order. I could get no definite history of hemorrhage. The clinical observations of the patient were very poor and meager.

DR. WILE: With regard to Dr. Peet's question, I am not prepared to answer because I have never

operated for either condition. But at the postmortem I think that one could tell rather easily by sectioning through the mass. The gummous mass, of course, does not as a rule look like carcinoma. In the one there is definite circumscription, in the other infiltration. The surface appearance of both is also quite different. The syphilitic process, of course, would start in the submucosa. I don't know that the surface appearance of the stomach without opening the organ would tell anything. I should think that one would find the peritoneal coat much more vascular in carcinoma. In syphilis the peritoneal surface is usually anemic. Glandular nodules occur, of course, quite commonly in syphilis.

SPINDLE CELL SARCOMA ARISING IN A CAVERNOUS LYMPH AND HEM- ANGIOMA OF THE MUSCULO- SPIRAL NERVE.

MAX MINOR PEET, M.D.

(From the Surgical Clinic, University Hospital, Ann Arbor, Michigan.)

Tumors of nerves occur very frequently, but are usually benign in character. Probably the best known type is the amputation neuroma which develops on the cut end of any large nerve and is usually painless unless caught in scar tissue. A less well known, but comparatively common type is the multiple neurofibromatosis which occurs in nerve trunks. This type is usually congenital, often shows a heredity tendency, and the tumors very seldom undergo malignant change.

The multiple nerve tumors which occur in the skin, a condition often spoken of as molluscum fibrosum or von Recklinghausen's disease and usually congenital, also rarely undergo malignant change.

The plexiform or cirroid neuromas, probably always congenital in origin, undergo malignant changes more often than those previously mentioned.

The type of nerve tumor found in the following case report, a cavernous lymph and hemangioma, is very rare and a rather careful review of the literature failed to disclose any tumors of this type which had undergone malignant change.

It is because of the rarity of the tumor and the few symptoms which it manifested as well as to call attention to a condition which was apparently benign until the operation revealed

its malignant character that the following case is reported.

Mr. H. B., age 65, was referred to us by Dr. Hawley of Bronson, Mich. He came to the University Hospital February 17, 1917, complaining of a small lump on the left arm, three inches above the elbow, which is painful on pressure. This lump was first noticed in October, 1916, at which time it was tender on pressure. Neuralgic pains are felt over the dorsum of the hand on the radial side. The tumor has increased slowly in size and is now felt as a smooth oval mass, the size of a small hickory nut, rather deep under the skin, to which it is not in anyway adherent. Slight pressure causes pain in the tumor and over the dorsum of the hand.

Because of the high blood pressure, 235, the operation for the removal of the growth was performed under local anesthesia.

On February 17, 1917, after preliminary intradermal infiltration with Schleich's solution an incision was made over the tumor and a rounded, more or less pyriform shaped growth exposed. The tumor was extremely sensitive to the slightest manipulation. This was overcome by injecting one-half c. c. of Schleich's solution directly into the musculospiral nerve above the tumor. On completely dissecting the mass it was found to embrace the nerve completely, the upper and lower ends of the growth tapering out on the nerve trunk. No nerve fibers could be seen passing in the capsule of the tumor and since many nerve tumors can be shelled away from the main nerve bundles, the hard, fibrous mass was split open longitudinally. No nerve fibers could be seen, but two cysts, one about a centimeter in diameter and the other smaller, containing a clear, slightly yellowish fluid, were disclosed in a solid mass of tissue resembling sarcoma. With the belief that the growth was malignant it was excised, the musculospiral nerve being cut about one centimeter above and below the mass. The nerve ends were united end to end by sutures of 000 silk and the line of approximation protected from the ingrowth of connective tissue by wrapping the nerve in a very thin sheet of celloidin. The wound was closed and the arm put up in the right angle position to prevent pulling on the nerve sutures. Wrist drop was of course present.

In a communication from Dr. Hawley, April 1st, he reports that the patient has had no pain since the operation, has excellent use of the arm, pronation and supination are unimpaired, and he is not hindered by the wrist drop.

If the nerve suture is successful, the action of the musculospiral nerve should return in six to eight months.

The pathologic report made by Dr. Warthin and Dr. Weller is: Spindle cell sarcoma arising in a cavernous lymph and hemangioma.

The unusual findings in this case, apart from the rare type of nerve tumor found are the late onset of symptoms, dating for only four months, although the tumor was undoubtedly congenital, and the fact that no nerve fibers could be demonstrated macroscopically, nor in the microscopic section for pathologic diagnosis, although no impairment in the muscles supplied by the musculospiral nerve existed prior to its necessary division at the operation.

The lack of pain until October last may be explained by the assumption that the tumor just before that time underwent malignant change and the consequent increase in growth pressed upon the nerve fibers.

CONCLUSIONS.

A cavernous lymph and hemangioma in which had arisen a spindle cell sarcoma, was found in the course of the musculospiral nerve, completely enveloping the nerve, but without the production of any symptoms except pain in the distribution of the nerve on the dorsum of the hand and in the tumor on direct pressure. The growth was apparently benign until its malignant character was revealed by operation. Painful tumors situated in the course of a nerve should be excised, as the possibility of malignancy always exists.

DISCUSSION.

DR. HARRY MALEJAN: I think Dr. Peet is to be congratulated on his successful operation in the removal of this tumor. In a great many of these cases which undergo sarcomatous degeneration, the function of the nerve is destroyed. It is interesting to note that in fibromata or neuromata of the nerve trunks of the arm, the median and ulnar nerves are usually affected. The musculospiral nerve is very rarely affected. I have never seen a report of the involvement of this nerve. In this case, of course, the musculospiral nerve was affected just above the elbow joint.

REPORT OF A CASE OF AMELANOTIC MELANOTIC SARCOMA.

H. M. MALEJAN, M.D.

AND

V. RUSSELL, A.B.

(From the Surgical Clinic, University Hospital, Ann Arbor, Michigan.)

In a recent report by Coley and Hoguet on ninety cases of melanotic cancer the following brief history of melanomas is given:

"Melanotic sarcoma or melanoma, one of the most common varieties of malignant tumors was first described as occurring in horses in the latter part of the 18th century. (Broguorne in 1784 and Satournelle in 1809). Lannaec was the first to write about this type of tumor in men. In 1806 Lannaec and Bayle published a report of cases of melanotic tumor of the lungs and other organs. For a number of years our knowledge of these tumors advanced but little except for the study of veterinary surgery which showed that they usually occur in animals with white skin and that the condition is hereditary and capable of transmission from one generation to another.

"The question as to the origin of these tumors is one much discussed and about which there is much disagreement. Discussion is rife even in our midst. One faction assures us that the etiology is epithelial while the other faction is equally positive that the origin is from the connective tissue. Probably both are right."

In our case, that of Mrs. E. W. the origin seems to have been from the connective tissue. The pathologic diagnosis on a gland which was removed from the neck intravital and which showed metastasis, was that the "tissue is entirely a malignant neoplasm of the type of an endothelioma. It shows no pigment." Naevi may give rise to nonpigmented sarcoma and the metastases are not always pigmented (Byrant & Buck Vol. VII, Page 387). Our diagnosis of melanotic sarcoma was confirmed antemortem.

Our patient, Mrs. E. W., age 37, entered the University Hospital Feb. 6, 1917, complaining of constant pain in the right shoulder radiating down the arm and into the fingertips. The family history was negative and unimportant. Personal history was negative. Examination revealed the source of trouble in the right supraspinatous region of the scapula. The sketches

and photograph (Fig. 1) made soon after the entrance of the patient show the lesion better than a description. I wish here to thank Miss Margaret Miller for her kindness in making these sketches. The history of the origin and treatment is quite typical. Four years ago in June the patient noticed, after bathing, that a dark, brown, flat spot about as large as her thumb nail had developed on the right shoulder since her bath the previous week. About a year later the pigmented area began to rise up from the surface of the skin and in a few weeks ulcerated spontaneously, yielding a sero-



Fig. 1. A Case of Amelanotic Melanotic Sarcoma.

sanguinous discharge and growing peripherally always in semilunar configuration. The patient described the ulcer as being "black as ink." Pain of a cutting character began to be troublesome.

From this time on till last December the history is that of recurrent ulceration and healing. There were visits to several physicians, and treatment ranging from actual cauterization and the application of salves of varied hue, to cranberry poultices. The cranberry poultices seemed to be the most efficacious and seemed to stop the pain though, strangely enough, not the spread of the ulcerating area.

At one time there was a period of healing when the scar presented red and smooth with no pigment. It remained so for a month. Then tiny black spots appeared at the border, enlarged and became confluent and finally formed a black lesion on the scar base. This broke down, crusted and ulcerated again and so on.

Two years ago a small, hard, painless lump developed on the right side of the neck. This grew gradually and when the patient came to us it was the size of an orange and very sensitive.

As has been noted before in similar cases, the very rapid decline of the patient from the time when she entered in apparently fair health, till her death five weeks later, seems to have been precipitated by her confinement in early January. The glands in the neck grew more rapidly from September on and pain in this region and down the arm started then. In December, however, the ulcer healed and remained so. While in bed following delivery and eight weeks before death, a small lump was noticed at the vertebral angle of the right scapula. At autopsy this was as large as a man's fist. The liver, though large and tender when she came in, increased appreciably in size almost from day to day.

The clinical picture was that of a steadily progressing cachexia with much sharp pain, sometimes in the arm, sometimes in the scapular region and again in the neck. Aspirin relieved this for a while and then codein became necessary. There was an intermittent nausea and vomiting. Two X-ray treatments were given. Three days after the first one the patient had a chill followed by a rise in temperature of 102.2° . From this time on her temperature showed irregular elevations.

Two weeks before death the patient noticed that her urine on standing became very dark colored. March 12th the ferric chlorid and bromine water tests for melanine were both positive on a twenty-four hour specimen. The skin during the last week had a faint icturic tinge. March 10th the patient had hallucinations and was mentally confused until the last day when she went into coma and died in cardiorespiratory failure, March 13th.

Patient was referred to Dr. Warthin's laboratory. At autopsy the healed scar was found

to be superficial. There was a conglomerate mass of pigmented glands imbedded in the tissues low in the right axilla and attached firmly to the inner surface of the scapula. The center was necrotic. In the right cervical region and connected beneath the clavicle with a mass in the right axilla was another mass of pigmented glands, also showing areas of caseation necrosis.

The liver was enormous, weighing 4,400 grams and extending on the right from the third intercostal space to about four fingerbreadths above the iliac crest and on the left to the nipple line in the fourth intercostal space and three fingerbreadths below the costal margin. It was made up of a mass of new metastatic nodules, varying in size from that of a millet seed to a walnut, and imbedded close together in atrophic liver substance. These nodules were soft and not pigmented. The larger ones had caseating centers.

The lungs showed numerous, buttonlike, subpleural, recent, nonpigmented metastases, mostly at the bases. A few were in the lung substance. There were a few small nonpigmented nodules in the spleen, as seen on section.

The mediastinum, bronchial lymph nodes and kidneys were macroscopically negative as regards metastases. The retroperitoneal lymph nodes were hyperplastic and dark gray.

These findings group the case with the melanomas showing visceral involvement in contradistinction to the other so-called "pepper seed" variety where the metastases are numerous bluish or blackish nodules in the skin.

Because of the relatively nonpigmented character of the sarcomatosis Dr. Warthin made a diagnosis from the gross of amelanotic melanotic sarcoma. A subsequent report will be made detailing the microscopic pathologic findings of this case and of several others.

Pharmacology of Stovaine.—M. I. Smith and R. Hatcher find that in toxic doses stovaine produces death in animals by inducing immediate and simultaneous paralysis of the heart and the respiration, the action on each being independent of the other. They find that stovaine disappears rapidly from the blood stream after its intravenous injection. Stovaine is slightly more toxic than novocaine by similar modes of administration and complete recovery does not follow the administration of toxic doses of stovaine so promptly as it does with corresponding doses of novocaine (*Jour. Pharm. and Exp. Thera.*, Jan., 1917, p. 231).

Hexamethylenamin in Pyelitis.—I. A. Abt advises caution in the administration of hexamethylenamin in the pyelitis of infants. It should be under continuous observation and its use should be continued for an extended period. The urine should be frequently examined for blood. Abt has more than once seen cases of fatal nephritis which he believes due to overuse of hexamethylenamin. He advises that, if even to infants under one year of age, it should be given in one grain doses followed by water. This dose may be repeated four or five times daily (*Jour. A.M.A.*, April 14, 1917, p. 1100).

Abolition of the Salvarsan Patent.—The Chicago Medical Society and the St. Louis Medical Society urge the abolition of the salvarsan patent. The patent should be abrogated, not only because the patentees have not supplied the demand, not alone because they have dictated to the medical profession who should have the drug and how much a physician might have, not alone because of the war with Ger-

many, not alone because of the special needs of the government at this time for the control of venereal diseases, not alone because, as some claim, the patent at Washington does not correctly describe the product, but also because the people who are supplying this product are charging prices that are exorbitant. In order that a sufficient supply, to control the ravages of one of the most serious diseases that afflict humanity, may be assured, it is the duty of Congress to abrogate the Salvarsan patent (*Jour. A.M.A.*, April 21, 1917, p. 1187 and 1203).

Examination of Ambrine and Various Paraffins.—P. N. Leech of the A.M.A. Chemical Laboratory reports on the composition and properties of Ambrine and the various preparations proposed for the treatment of burns. He finds that the French proprietary Ambrine—exploited in the United States as Hyperthermine and Thermozine—is essentially paraffin in which a small amount of a fatty oil and asphalt is incorporated. A preparation similar in composition but superior to Ambrine in physical properties may be made by dissolving 3 to 5 drops asphalt varnish in 1.5 cc. of olive oil and adding this to 97.5 gm. melted paraffin melting at 47.2 C. It is probable that for most purposes simple paraffin will answer just as well as Ambrine or the mixture proposed in its place. Whether used alone or in mixtures, the physical properties of the paraffin are most important. Paraffin U. S. P. will not answer, and hence the properties of many commercial brands of paraffin were determined and the best products are designated. (*Jour. A.M.A.*, May 19, 1917, p. 1497.)

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July

Editorials

PATRIOTIC COMMITTEES.

We trust that every component society has accomplished the appointment of its local Patriotic Committee. Please be certain that the name of the chairman of your committee has been forwarded to the State Secretary. Likewise promptly report the names of all your members who have gone forth to active service.

In order that our supervision of the interests of each enlisted member may be effectual it is imperative that informative data be promptly submitted. We are keeping a tabulated record of every enlisted doctor and desire the fullest information attainable.

These Patriotic Committees are charged with important duties. The Council insists that you become and continue aggressively active. Please answer all communications promptly.

NEWS FROM THE FRONT.

We have written to some and extend the invitation to all of our members who enter into service in the army or navy to write to *The Journal*. Your fellow members at home will be exceedingly eager to learn what you are

doing and to read of your experiences. Your Editor invites your correspondence.

We know you will be busy, still we nourish the hope that you will be able to find the time to write to us "From Somewhere." Send us photographs, if the censors will permit, and impart such information and description as may be transmissible through the mails.

If the response is sufficient we propose establishing a special department for the publication of correspondents' contributions.

ORIGINAL ARTICLES.

The postponement of our annual meeting threatens our editorial drawer of original articles with complete depletion. The source of our original articles has been mainly the papers presented at the sessions of our several scientific sections. Consequently we are approaching the end of that supply.

We take this opportunity of soliciting carefully prepared, timely and instructive original articles from our members. Please utilize the opportunity of what leisure time you have available to contribute, for publication, to your *Journal*.

WAR SURGERY.

Can we at the present time draw definite conclusions or enunciate new principles and methods of treatment with any degree of assurance that they are tenable? We are of the opinion that the experiences encountered in field, evacuation and base hospitals are not, as a whole, applicable to civil practice.

Prominent in our literature are articles presenting statistics, summaries, principles and conclusions. Our medical gatherings are being addressed by speakers who have served periods of three months to two years in foreign hospitals. Dogmatic statements are being made—many of them unwarranted. Were we to believe all that is being spoken and written we would indeed feel that we were resting on crumbling foundations of erstwhile surgical principles that must now be cast aside for these newer things.

We are being told that compound-comminuted fractures should be treated by early amputation. That wounds opening the knee joint will result in death if amputation be not promptly performed. That in comminuted-compound fractures of the hip if the head of the femur is not disarticulated death will promptly result. That tap-water is as effective as iodine. That in wounds of the soft parts the exposed area should be immediately excised. These are but a few of the dogmatic enunciations of certain returned enthusiasts. We protest against them and decry the efforts set forth seeking to secure the adoption of these practices in present day emergency and industrial surgery.

While it may be true that the observance of these practices in field and base hospitals is accomplishing a lowered mortality the same conditions do not prevail in civil practices. We are told how these military surgeons are overworked—of the thousands wounded brought in in a single day. How the demand of operative treatment is so heavy that the after-care is by necessity delegated to nurses and meagerly trained helpers. It is no wonder then that the primal operative procedure must of necessity be radical and hurried with complete ignoring of finer details and principles. The surgery performed is perforce devoid of constructive and conservative measures. It may be true that this is necessary for military purposes and exigencies; it does not follow that the same is applicable to civil practice.

We are still possessed of the assurances that conservation is applicable in our civil surgery and that with deliberate operative work, detailed and careful post-operative care amputations, infections and fatal complications may be circumvented. The surgeon who has served in a military hospital must needs readjust himself to civil practice or be considered as "hewer of limbs" whose methods are unsafe, unwarranted and uncalled for in present day industrial and emergency surgery.

UNPAID DUES.

The following is a list of members whose dues were unpaid on June 1st, 1917. Their

names were removed from our mailing and membership lists and these men are now classified as suspended. They are also without the protection of the Defense League.

We are unwilling to see these men drop out of the ranks. Many of them have permitted their membership to lapse by reason of carelessness. We urge that the list of your county be perused and that you personally call the attention of these men to their suspension and that the necessary steps be taken to become re-instated.

ALPENA.

J. W. Small Alpena
A. A. Stuart Lincoln
John Wilson Spruce

ANTRIM, CHARLEVOIX, EMMET.

C. J. Beaver Mancelona
A. T. Bodle Bellaire
J. B. Brown Levering
J. E. Dobson Pellston
W. H. Marshall Boyne City
R. R. Miller Harbor Springs
E. R. Moorman Pellston
C. J. O'Brien Pellston
W. H. Parks East Jordan
W. W. Walton Almira
R. H. Wessels Mancelona

BARRY.

G. W. Lowry Hastings
S. C. McIntyre Woodland
J. W. Rigtterink Freeport

BAY.

C. W. Ash Bay City
S. L. Ballard Auburn
V. H. Dumont Bay City
Nina Ely Bay City
E. J. M. Flynn Bay City
H. M. Gale Bay City
J. A. Keho Bay City
R. McGeogh Bay City
J. McLurg Bay City
G. P. McNaughton Standish
G. E. Orth Linwood
F. H. Randall Bay City
R. E. Scrafford Bay City
A. F. Stone Bay City
Albert Stealy E. Tawas
C. M. Swantek Bay City
G. W. Trumble Bay City
V. L. Tupper Bay City
E. C. Warren Bay City
A. J. Zarembo Bay City

BENZIE.

H. J. Kinne Frankfort
F. H. Stone Beulah

BERRIEN.

F. H. Coone St. Joseph
R. B. Howard Three Oaks
D. D. J. Hoyr New Troy
F. N. Martin St. Joseph
A. A. Rosenberry Benton Harbor
A. Z. Van Noppen Niles
E. J. Witt St. Joseph

CALHOUN.

E. K. Harris Battle Creek
L. L. Joy Marshall
H. M. Lowe Battle Creek
E. J. Pendall Marshall
F. W. Phillips Battle Creek
J. L. Ramsdell Albion
C. R. W. Southwick Olivet
L. E. Westcott Ceresco

CASS.

S. L. Loupee Vandalia

CHEBOYGAN.

A. J. Sahs Cheboygan

CHIPPEWA.

E. H. Campbell Newberry
A. McCandless Sault Ste. Marie

CLINTON.

Henry Cook Fowler
M. S. Gregory Eureka
C. R. Keller Maple Rapids
E. L. Martin Maple Rapids
A. M. Switzer Elsie

DELTA.

Fred Baker No. Escanaba
G. C. Bartley Escanaba
O. F. G. Bjorkman Gladstone
M. P. Fenelon Escanaba
W. A. Lemire Escanaba
A. F. Snyder Escanaba
Louis Treiber Bark River
E. R. Wescott Spalding

DICKINSON-IRON.

J. A. Crowell Iron Mountain
A. M. Darling Crystal Falls
M. F. Dockery Sagola
J. O. P. Edwards Alpha
R. E. Hayes Channing
C. F. Larson Crystal Falls
E. M. Libby Iron River
W. McBurney Stambaugh
E. B. McDaniel Crystal Falls
A. A. Metcalf Crystal Falls
W. S. Stevens Iron River

EATON.

J. B. Bradley Eaton Rapids
H. W. Kenfield Mulliken

C. L. McLaughlin Vermontville
W. H. Rand Charlotte
J. T. Warford Mulliken
C. B. Wassan Bellevue

GENESEE.

M. E. Chandler Flint
A. B. Clark Swartz Creek
P. M. Crawford Flint
A. R. Ingram Fenton
B. G. McGarry Fenton
J. W. Parker Grand Blanc
J. Scheidler Flushing
J. R. Shank Flint
J. D. Stuart Flint
H. R. Thomas Flint

GOGEBIC.

L. O. Houghton Bessemer

GRAND TRAVERSE, LELANAU.

G. L. Fenton Kingsley
F. C. Mayne Traverse City
W. M. Payne Suttons Bay

GRATIOT, ISABELLE, CLARE.

J. S. Bender Bannister
C. E. Burt Ithaca
C. M. Denny Middleton
W. M. Drake Breckenridge
A. T. Gretchell Mt. Pleasant
D. M. Langan Harrison
F. C. Sanford Clare
W. A. Sayers Mt. Pleasant
J. R. Shaffer Elm Hall
F. C. Thornburgh Alma

HILLSDALE.

W. R. Ditmars No. Adams
H. H. Frazier Hanover
W. H. Sawyer Hillsdale

HOUGHTON.

J. C. Abrams Calumet
R. E. Ames Cincinnati
G. W. Orr Lake Linden
C. H. Rodi Calumet
W. H. Van Slyke Hancock

HURON.

D. J. Monroe Elkton
S. Stevens Uby

IONIA.

J. C. Fleming Pewamo
O. P. Geib Hubbardston
H. B. Knapp Ionia
F. W. Martin Portland

INGHAM.

C. M. Davis Lansing
F. H. Harris Lansing
J. B. Park Okemos
L. C. Towne Lansing
L. F. Weaver Lansing

JACKSON.

Ferdinand Cox Horton
 H. G. Glover Jackson
 W. N. Lake Grass Lake
 E. M. Palmer Brooklyn
 A. R. Williams Jackson

KALAMAZOO.

B. T. Butler Kalamazoo
 F. A. Butterfield Lawrence
 J. F. Chapin Schoolcraft
 Milton Chase Otsego
 L. E. Clark Otsego
 R. N. Dunnington Hartford
 A. H. Gifford Alamo
 A. M. Hutton Oshtemo
 H. B. Osborn Kalamazoo
 H. S. Smith Schoolcraft
 B. H. Southworth Schoolcraft
 Howard Stuck Allegan

KENT.

W. S. Bell Grand Rapids
 H. M. Blackburn Grand Rapids
 J. E. Bolander Sparta
 R. C. Breece Ada
 E. S. Browning Grand Rapids
 J. Buersma Grand Rapids
 E. J. Byers Grand Rapids
 H. W. Dingman Grand Rapids
 W. J. DuBois Grand Rapids
 C. H. Fairbanks Grand Rapids
 F. S. Fannoff Grand Rapids
 Wm. Fuller Grand Rapids
 J. A. Heasley Grand Rapids
 Jas. Henry, Jr. Grand Rapids
 C. B. Hernam Grand Rapids
 J. B. Hilliker Grand Rapids
 C. E. Hooker Grand Rapids
 W. A. Hyland Grand Rapids
 R. J. Kirkland Grand Rapids
 M. A. Leach Grand Rapids
 A. M. Martin Grand Rapids
 R. Maurits Grand Rapids
 P. S. Miller Grand Rapids
 C. A. Moon Grand Rapids
 J. R. Rogers Grand Rapids
 J. W. Shanks Grand Rapids
 D. S. Sinclair Grand Rapids
 C. C. Slemons Grand Rapids
 G. J. Stuart Grand Rapids
 S. D. Swantek Grand Rapids
 M. L. Teeple Sand Lake
 R. T. Urquhart Grand Rapids
 W. H. Veenboer Grand Rapids

LAPEER.

J. H. Burley Almont
 G. W. Jones Imlay City
 Paul Thompson Lapeer

LENAWEE

We have received no remittance for Lenawee County for 1917 dues.

LIVINGSTON.

B. H. Glenn Fowlerville
 E. B. Pierce Howell
 J. D. Singer Brighton

MACOMB.

H. G. Berry Mt. Clemens
 W. F. Lungerhausen Mt. Clemens
 C. M. Mann Halfway
 J. F. O'Keefe Mt. Clemens
 A. A. Parisot Mt. Clemens
 J. H. Seaman New Haven
 A. N. Shotwell Mt. Clemens
 A. J. Warren Mt. Clemens
 W. D. Wilson Mt. Clemens
 V. H. Wolfson Mt. Clemens

MANISTEE.

S. H. Cornell Copemish

MARQUETTE-ALGER.

R. S. Buckland Baraga
 H. M. Cunningham Marquette
 C. J. Larson Negaunee
 H. A. Sharpe L'Anse

MASON.

J. H. Carnelly Ludington
 I. L. Hunt Scottville
 E. J. Kirwan Ludington
 F. McCandless Ludington

MECOSTA.

R. P. Allen Remus
 John Snyder Mecosta
 W. A. Whitney Big Rapids

MENOMINEE.

B. W. Jones Vulcan
 L. W. Palmer Hermansville

MIDLAND.

All paid.

MONROE.

All paid.

MONTCALM.

D. K. Black Greenville
 V. H. Hargrave Carson City

MUSKEGON-OCEANA.

J. F. Denslow Muskegon

NEWAYGO.

W. C. Tompsell Hesperia

OAKLAND.

G. F. Hamlen Rochester
 B. H. Spencer Rochester

O.M.C.O.R.O.

J. H. Abblett Fairview

ONTONAGON.

All paid.

OSCEOLA, LAKE.

All paid.

OTTAWA.

Jos. DePree	Zeeland
P. H. Fisher	Hamilton
J. F. Peppler	Wyoming Park
F. D. Smith	Coopersville
G. H. Thomas	Holland
W. J. Vandenberg	Holland
A. Vander Veen	Grand Haven
W. S. Walkley	Grand Haven

PRESQUE ISLE.

L. C. Kent	Onaway
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SAGINAW.

B. H. Beckwith	Saginaw
R. B. Bennett	Brant
W. A. DeFoe	Saginaw
A. R. Ernst	Saginaw
G. H. Ferguson	Saginaw
J. J. Fitzgerald	Saginaw
R. O. Fuerbringer	Saginaw
Arthur Grigg	Saginaw
E. M. Ling	Merrill
J. A. McLandress	St. Charles
J. W. McMeekin	Saginaw
W. L. Miller	Saginaw
E. A. Pillsbury	Frankemuth
M. D. Ryan	Saginaw
T. L. Ryan	Saginaw
L. B. Stewart	Chesaning
C. S. Watson	Saginaw
R. S. Watson	Saginaw
T. M. Williamson	Saginaw
P. S. Windham	Saginaw

SANILAC.

J. E. Campbell	Brown City
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SCHOOLCRAFT.

All paid.

SHIAWASSEE.

A. L. Arnold	Owosso
H. L. Arnold	Owosso
L. M. Cudworth	Perry
H. A. Hume	Owosso
C. McCormick	Owosso
C. B. Porter	Owosso
G. A. Sackrider	Owosso
Milton Shaw	Clinton, Ont.
G. O. Switzer	Ludington
F. A. Watts	Owosso
H. T. White	New Lothrop
P. S. Willson	Owosso

ST. CLAIR.

C. A. McPherson	St. Clair
E. P. Tibbals	Port Huron

ST. JOSEPH.

Ray E. Dean	Three Rivers
P. L. Hartman	Colon
D. M. Kane	Sturgis
J. H. Moe	Sturgis
F. W. Robinson	Sturgis

Marden Sabin	Centerville
A. A. Wade	Howe, Ind.

TRI COUNTY.

R. Brodeur	Cadillac
E. S. Niehardt	So. Boardman

TUSCOLA.

A. E. Copp	Tuscola
J. E. Handy	Caro
H. H. King	Colling
I. D. McCoy	Cass City
L. M. Ryan	Caro
W. A. Wellemeyers	Vassar

WASHTENAW.

J. R. Breakey	Ypsilanti
H. W. Emerson	Ann Arbor
Q. O. Gilbert	Ann Arbor
A. W. Hewlett	Ann Arbor
W. A. Hoyt	Ann Arbor
H. S. Hilbert	Ann Arbor
H. H. Johnson	Ypsilanti
W. A. Kloppenstein	Manchester
F. M. Loomis	Ann Arbor
I. D. Loree	Ann Arbor
F. F. Pyle	Milan
A. S. Warthin	Ann Arbor
C. L. Washburne	Ann Arbor
J. S. Wendel	Ann Arbor
F. N. Wilson	Ann Arbor

WAYNE.

Jos. Aarons	Detroit
F. B. Allison	Detroit
C. G. Anderson	Detroit
W. R. Baker	Detroit
V. D. Barnes	Detroit
G. C. Bassett	Detroit
R. Beattie	Detroit
W. C. Bell	Dearborn
C. C. Benjamin	Detroit
A. E. Bernstein	Detroit
John Blake	Detroit
A. C. Blakeley	Detroit
T. F. Brady	Detroit
E. L. Brandt	Detroit
J. N. E. Brown	Detroit
A. E. Bryant	Detroit
G. B. Bulson	Detroit
G. Bundy	Detroit
J. E. Burgess	Detroit
F. B. Burke	Detroit
F. E. Callister	Detroit
C. A. Campbell	Detroit
G. C. Caron	Detroit
R. H. Carmichael	Detroit
J. E. Casey	Detroit
D. R. Clark	Detroit
H. R. Call	Detroit
C. C. M. Conley	Detroit
G. L. Connor	Detroit
B. F. Corbett	Detroit
C. G. Crumrine	Detroit

R. F. DeBlois	Detroit	John Lee	Detroit
V. C. Doherty	Detroit	C. J. Lehman	Detroit
L. J. Dretzka	Detroit	R. S. Linn	Detroit
M. S. Dubpernell	Detroit	J. S. Lipsky	Detroit
F. Duffield	Detroit	P. J. Livingstone	Detroit
S. Duffield	Detroit	W. J. Lovering	Detroit
G. C. Duggan	Detroit	L. W. Lyon	Detroit
E. W. Eede	Detroit	J. H. McCann	Detroit
J. E. Emerson	Detroit	T. McClure	Detroit
A. Fellman	Detroit	F. T. McCormick	Detroit
W. A. Fenner	Detroit	Grant McDonald	Detroit
G. H. Fielder	Detroit	G. H. McFall	Detroit
L. R. Fitzgerald	Detroit	G. H. McMahon	Detroit
O. A. Fischer	Detroit	A. McMichael	Detroit
C. A. Fisher	Detroit	W. M. Manton	Detroit
N. M. K. Fisk	Detroit	A. Metzner	Detroit
O. C. Fluemer	Detroit	W. E. Miller	Detroit
H. E. Fogt	Detroit	E. T. Milligan	Detroit
L. Galton	Detroit	C. G. Morris	Detroit
I. S. Gellert	Detroit	A. R. Moon	Detroit
D. L. Gordon	Detroit	C. W. Morey	Detroit
A. H. Gorenflo	Detroit	P. F. Morse	Detroit
F. J. Grandfield	Detroit	J. W. Neary	Detroit
H. W. Green	Detroit	H. E. Northrup	Detroit
A. J. Griffith	Detroit	R. W. Odell	Detroit
W. Gramley	Detroit	Burton Ray	Detroit
B. J. Hamilton	Detroit	T. H. O'Rourke	Detroit
R. J. Hamlen	Detroit	A. P. Ohlmacher	Detroit
G. C. Hardy	Detroit	Howard Osborn	Detroit
B. D. Harison	Detroit	F. R. Ostrander	Detroit
A. E. Harris	Detroit	E. J. Panzner	Detroit
W. M. Harvey	Detroit	F. J. Przybylowski	Detroit
M. G. Haskins	Detroit	M. B. Robinson	Detroit
P. F. Hasley	Detroit	E. Rodd	Detroit
O. H. Heidt	Detroit	F. D. Royce	Detroit
E. W. Henderson	Detroit	W. D. Ryan	Detroit
L. T. Henderson	Detroit	J. W. Schureman	Detroit
Thos. Henderson	Detroit	T. Sigel	Detroit
W. R. Henderson	Detroit	G. K. Sipe	Detroit
L. H. Herbert	Detroit	Eugene Smith, Sr.	Detroit
Max Herrman	Detroit	Eugene Smith, Jr.	Detroit
C. W. Hitchcock	Detroit	A. M. Stirling	Detroit
J. J. Howard	Detroit	J. D. Stuart	Detroit
A. M. Humber	Detroit	L. C. Thomas	Detroit
W. H. Hutchings	Detroit	E. D. Tichnor	Detroit
F. W. Hyde	Detroit	T. Walker	Detroit
Nathan Jenks	Detroit	C. E. Watson	Detroit
E. B. Keeler	Detroit	O. B. Weed	Detroit
J. B. Kennedy	Detroit	A. B. Wickham	Detroit
W. Y. Kennedy	Detroit	W. J. Wilson, Sr.	Detroit
J. A. Kinzey	Detroit	J. A. Winter	Detroit
A. W. Kipp	Detroit		
M. E. Kohn	Detroit		
E. P. Koneczny	Detroit		
S. A. Kulick	Detroit		
P. A. Klebba	Detroit		
W. C. Lambert	Detroit		
W. P. Lane	Detroit		
O. H. Lau	Detroit		
T. M. Lawton	Detroit		
M. A. Layton	Detroit		
A. C. Lee	Detroit		

INDIANA GRAFT.

The following needs but little comment. Needless to add that we know Indiana doctors are not of this type:

1801 South Penn St.
Muncie, Ind.

Mr. C. T., 195 Spring St.,
Muskegon Mich.

My Dear Mr. T.

Your son Glen, I believe it is, is treating with

me and I find he is suffering from appendicitis due to the pressure against that organ and the bowel of a dislocated kidney, the latter causing appendicitis and prostatic trouble and will soon lead to the development of acute appendicitis and peritonitis, plus bladder and kidney inflammation and a general state of debility and nervous collapse.

I am practicing surgery here, having been forced to leave Cin. on account of my health.

I was the first surgeon to originate a successful operation for dislocated kidney and to investigate its pathological importance and relation to abdominal troubles, etc., etc.

Every surgeon of any prominence in Europe and America is now using my operation, and has recognized my work on the subject as authoritative.

In Cin. I taught anatomy and surgery in five colleges: Two medical, two dental and one for doctors.

I will take the boy in my home and give him the best that a good surgeon and a christian home can offer. It will cost him, operation, hospital attention (my home) nursing and all, between \$100 and \$125, and as I expect to go to a large city in a few weeks 5-7, to take a college position, I would advise action as soon as possible. He has some money, about \$50, I believe, but needs some more, enough to make out the above amount.

Under separate cover I am mailing address delivered years ago on the subject. Please read it and return it as soon as possible, as it is all I have here. The operation was done on me with perfect success and hasn't been changed except a little in one or two details.

I would like to hear from you at your earliest convenience.

Very cordially yours,

Dr. E. H.,

1801 South Penn St.

Muncie, Ind.

Correspondence

Battle Creek, June 13, 1917.

Dr. F. C. Warnshuis, Powers Theater Bldg.,
Grand Rapids, Michigan.

My dear Dr. Warnshuis:

We have received your circular letter relative to appointing a County Patriotic Committee, and I have the honor to report that the committee for Calhoun County as appointed by the President, who is himself Chairman of the Committee consists of the following members beside the President, Dr. W. L. Godfrey.

Dr. E. L. Parmeter, Albion.

Dr. Chas. E. Stewart, Sanitarium.

Dr. W. H. Haughey, 24 W. Main St.

Dr. R. V. Gallagher, Post Building.

The machinery for collecting the extra \$5.00 assessment is about ready to be set in motion. Already two members have paid their assessment.

We very much desire to know what items are to be included in the assistance to be cared for by the State Society for the benefit of enlisted members. I am asking this as it is very necessary for our Society since we presume to care for certain items for our own members, provided they are not looked after by the State Society. It is our purpose to see that each enlisted man shall have no anxiety regarding the paying of life insurance premium up to \$8,000 per member. That his taxes on \$4,000 of property shall be paid, and that his fire insurance on his property shall be paid. This much aside from being sure that his family suffers no distress during his absence. Of course, his Society dues will be remitted and a plan has already been set in motion whereby a goodly amount of equipment is being paid for.

You understand we do not wish to double up with the State Society and it would seem this should be taken care of by the State Society rather than by the Local Society, and that a sufficient assessment to accomplish this should be levied. We would very much appreciate a promptly reply.

A. F. KINGSLEY, Secretary.

Rudyard, June 11, 1917.

Dr. Warnshuis, Grand Rapids, Mich.

Dear Doctor:

I have passed my examination and have my papers in to Washington for the Medical Officers Reserve Corps.

If I am called upon to go to the war zone or to a training camp, do you know of any physician not of military age whom I could get to take care of my practice while I am away.

I am the only physician here and would not like to leave without making arrangements to have some other physician take over the practice.

Yours very truly,

R. D. SCOTT.

June 15, 1917.

Dr. F. C. Warnshuis, Secretary
Michigan State Medical Society,
Grand Rapids, Michigan.

I am in receipt of your letter of June 4th enclosing resolution passed by the Michigan State Medical Society at its meeting on May 10, 1917, and have taken the matter up with Surgeon General Gorgas.

Very truly yours,

FRANKLIN MARTIN,
Member of The Advisory Commission.

Deaths

Dr. James E. Taylor of Ovid dropped dead as a result of heart trouble, May 13th. He had been suffering for several months from an extreme case of heart trouble but it was hoped that if he was cautious not to overdo, he might recover.

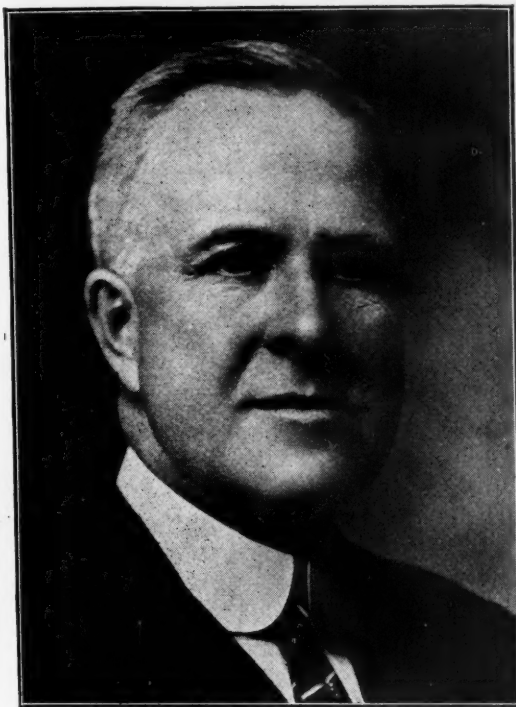
Dr. J. A. Winter of Detroit died at his home, June 4, after a lingering illness. Funeral services were held from the Masonic Temple in charge of the Knights Templar.

Following are a number of deaths of doctors not belonging to the State Society. Dr. Samuel Robinson of Sturgis, Dr. J. H. Dobson of Bel-
laire, Dr. Roy Freeland of Detroit, Dr. Abler of Plymouth, Dr. F. L. Smith of Detroit, and Dr. Frank V. Stutzke of Detroit.

W. L. Dickinson, A.M., M.D. It has been our good fortune to know the late Dr. W. L. Dickinson for many years, as but few men knew him. It may be safely said we do not know men until we know them well, as only then do those inborn hidden qualities reveal the truer life of the individual which is not observed as men meet and pass in business affairs. Such associations with the deceased enables us to note the serious loss to the community and the medical profession by his death. He came into manhood among the hills of a New York farm, an event he cherished as his greatest inheritance and to which source may be attributed the foundation of his rugged industrious nature and sturdy honesty. He was a man of splendid scholarship and culture, having obtained his M.A. degree from Taylor University and M.D. from the University of Buffalo. Although devoted to his profession, which he believed transcends the benevolence of all other crafts in the administration of Christian charity, he gave much time in a quiet way to literary and philosophic work, and in his library may be seen the later writings on modern electricity, science and mechanics.

He was a member of the A.M.A., the State Medical Society and the American Proctological Society, a specialty he followed for 25 years, and in

which he gained an enviable reputation. He was formerly president of the Saginaw County Medical Society and for many years president of the Medical Staff of the Women's Hospital. He had profound faith in the honor and fidelity of his confreres in the profession and rarely missed a gathering or meeting in their interests. Of stern will and strong convictions, his manner gave expression of independence and conclusions largely his own, and although charitable, kind and sympathetic to the last degree, he made no compromise to save his



W. L. DICKINSON, A.M., M.D.
1854-1917.

reputation for consistency or to secure immunity from criticism of his friends. He was inclined to follow the path of duty, rather than what policy dictated, and to subordinate all things to truth and what seemed to him to be right.

It may be reverently stated that our language owes a gratitude for the excellent characteristics that have secured for him a worthy remembrance and immortality in the minds of his associates.

He was a life long member of the Methodist Episcopal Church and of the Knights Templar, under whose auspices funeral services were conducted at his residence in Saginaw, June 10th, and his body returned to his childhood's home in West Webster, New York, for burial, after two score years of honorable activity in his adopted state.

W. F. ENGLISH, M.D.

State News Notes

The Detroit College of Medicine and Surgery graduated a class of 64 on June 1st. The degrees were conferred by the President. The faculty address was delivered by Dr. Angus McLean and the valedictory by C. G. Woodhull.

MARRIED: Dr. W. T. Dodge of Big Rapids and Miss Mulvey of Alma were united in marriage on June 25th, at Alma. After a short "auto-honeymoon" they will be at home to all the members of the State Society.

Dr. E. E. Hendershot has been appointed health officer of Adrian. He succeeds Dr. H. H. Hammel who has entered training at Fort Benjamin Harrison.

Dr. H. Ostrander of Kalamazoo was elected as one of the councilors of the Medico-Psychological Society of America at its annual meeting in New York.

Please note the advertisement of the Michigan Auto Owners' Association in this issue. We personally recommend this organization.

Dr. F. A. Roberts of Flint has been appointed Captain of the Ambulance Corp that is being recruited by Knight Templars of Michigan.

Dr. C. C. Huber of the U. of M., delivered the annual address before the Alpha Omega Alpha at Minneapolis.

Dr. E. L. Eggelston of Battle Creek delivered the graduating address to the class of the Albion City Hospital.

Dr. Wade Stewart Forth of Manistee and Miss Nan Romans of Portage Lake were married June 16th.

Dr. Warren L. Babcock has been elected President of the Wayne County Society with Dr. Ray C. Andries as Secretary.

County secretaries will please send in the name of the chairman of their Patriotic Committee.

Dr. Chas. Lynch has resigned as Health Officer of Lansing.

Dr. F. C. Theide has been appointed city physician of Monroe.

Dr. G. P. Morison has been appointed pension examiner for St. Joseph county.

Dr. Bellinger of Bath has moved to Lansing.

Dr. W. C. Kools has become associated with Dr. W. G. Winter of Holland.

Dr. G. P. Morison has been appointed Health Officer of Sturgis.

Dr. R. G. Leland, Health Officer of Kalamazoo, has resigned and is now at Fort Benjamin Harrison.

Dr. C. S. Ballard has been elected city physician for Flint.

Dr. A. W. Blain of Detroit announces the limitation of his practice to surgery.

County Society News

EATON COUNTY

Third annual meeting of Eaton County Medical Society.

1. "The use of Digitalis," by John G. Gage, Battle Creek. This paper was a very valuable one to the General Practitioner and was appreciated by all present.
2. "Military Surgery," by Leo C. Donnelly, M.D., Detroit.

(Brief of Doctor Donnelly's paper is found below.)

Doctor Donnelly's paper was based upon his experiences at the Orthopedic Hospital No. 43 conducted by R. R. Fitch, ex-Secretary of the American Orthopedic Society. This Base Hospital is situated back of the Somme and is rapidly becoming one of the large orthopedic centers in France.

Doctor Donnelly gave a resume of the Surgical problems that were met with in the War Zone.

The Carrel-Dakin treatment comprising a continuous disinfection of the mechanically cleansed wound tract by a .5 per cent. sodium hypochlorite solution is a gaining support and is becoming the standard treatment in the Allied Hospitals. Many British Hospitals are still using the Wrights' Concentrated Sodium Chlorite solution, salt-wick and salt pack dressing. Ether, iodine, alcohol, eau de taveli, labarraquis solution, etc., are still used according to the ideas of individual surgeons.

All surgeons are attempting early closure of wounds, and many are making bacteriological examination of the wounds, and closing them soon as they are bacteria free. Wounds are closed by secondary sutures or drawn together by means of adhesive strappings or by hooks and laces attached to muslin, the latter is fastened to the edges of the wound by a Gum Arabic preparation.

The French use plaster of paris largely to immobilize their fractures, as the majority of fractures are compound and are infected, large reinforced fenestrated casts are used.

The British are using braces and extension apparatus following the teachings of Robert Jones of Liverpool. Osteomyelitis is a dread complication of compound fractures and it offers the same stubborn problem in the war zone as it does in civil practice. Bone plates are applied even in the presence of pus in order to maintain proper alignment. These wounds are left open and the plate removed as soon as callus forms.

It is the desire of the French Service de Santi that all foreign bodies be removed, since the psychic effect on the patient is bad. American surgeons are loath to remove deeply placed missiles unless they give rise to symptoms.

Antitetanic serum has practically stamped out tetanus. Gas gangrene is less plentiful due to the more prompt and efficient methods of combating sepsis. After it has appeared, very free incision, removal of the pressure and exposure to oxygen seem to be the best measure of combating the infection.

The end results of head, chest and abdominal surgery is very discouraging and the mortality high.

Nerve surgery is still in the experimental stage and as yet the end results are not known.

G. W. BYINGTON, Secretary.

SANILAC COUNTY

The quarterly meeting of Sanilac County Medical Society was held at Peck on Friday, June 8 at 1:30 p. m. Dr. Neil J. McColl, President of the Society, presiding. The following members were present:

Drs. Neil J. McColl, H. H. Learmont, W. T. Campbell, J. W. Webster, L. E. Coelman, J. G. Waltz, C. G. Robertson, J. W. Scott. Visitors: Drs. J. M. Jones, Bay City; M. Lenehan, Jones Clinic, Bay City; Chester Emmett, Wright, Yale.

The President of the Society called the meeting to order and introduced Dr. Lenehan, who gave a talk on "Prostatectomy," discussion offered by Dr. J. W. Webster, followed by the members of the Society: Dr. J. M. Jones, Bay City, was then introduced and gave a talk on "Diagnosis and Surgical Treatment of Gastric Ulcer." General discussion followed.

The following committees were then appointed:

Committee on Red Cross Medical Work: Drs. L. E. Cochran, James A. Fraser, Edward Meyer, exofficio members of Committee, Drs. Neil J. McColl and J. W. Scott.

County Medical Society Patriotic Committee: Drs. C. G. Robertson, J. T. Waltz, H. H. Learmont.

Moved and supported and carried that our next meeting be held on the Beach at Lexington on July 18 and that the Medical Societies of St. Clair, Lapeer, Huron and Tuscola be invited and that the meeting be of a social as well as medical character. The following members were appointed a committee on arrangements: Drs. N. J. McColl, H. H. Learmont, Jas. A. Fraser. The meeting extended a hearty vote of thanks to Drs. Jones and Lenehan.

On motion the meeting was adjourned.

J. W. SCOTT, Secretary.

Book Reviews

IMPOTENCY, STERILITY AND ARTIFICIAL IMPREGNATION. Frank P. Davis, Ph.B., M.D. C. V. Mosby & Co., St. Louis, Mo. Cloth, 138 pp.

An excellent guiding discussion of a subject demanding greater professional attention and consideration.

ACUTE POLIOMYELITIS. George Draper, M.D., Associate in Medicine, Columbia University. Foreword by Simon Flexner, M.D. Cloth, 149 pp. Price \$1.50. P. Blakeston's Son & Co.

This is a splendid, instructive discussion of the author's experiences and observation of this disease during the recent New York epidemic. It is a practical guide to the diagnosis, care and specific treatment of the disease. Its appearance at this time is opportune as we know not what the summer has in store. All in all it is an experimental book brought right up to date. We urge its study.

THE INTERNAL SECRETIONS, Their Physiology and Applications to Pathology, by Dr. E. Gley, Professor of Physiology in the College of France, Etc., translated from the French and edited by Dr. M. Fishberg. 12 mo. Cloth, 240 pp. Price (about) \$2.00 net. Paul B. Hoeber, Publisher, 67-69 East 59th Street, New York.

Professod Edward A. Schafer in the preface of his monograph on "Then Endocrine Organs," says:

"For a concise history of the subject as well as a critical examination of the main facts on which the doctrine of internal secretions is based, the small but masterly compendium, by E. Gley cannot be too warmly recommended."

With the subject matter brought up to date, a scholarly translation should at this time be particularly welcome to the English speaking profession.

CANCER, ITS CAUSE AND TREATMENT. By L. Duncan Bulkley, A.M., M.D., Senior Physician to the New York Skin and Cancer Hospital, Etc. 12 mo. Cloth, 250 pp. \$1.50 net. Paul B. Hoeber, Publisher, 67-69 East 59th St., New York.

This book presents the medical aspects of cancer and its control by dietetic and medical treatment, with illustrative cases. While under medical guid-

ance the death rate of tuberculosis has decreased over 25 per cent. since 1900, the death rate of cancer has increased over 25 per cent. during the same period, under surgical care.

The author presents a strong argument, with reasons, for the constitutional origin of cancer and the treatment of its basic cause, while acknowledging that in some instances it may be necessary or best to remove the local lesion, or product of the disease, by surgical means.

OPINIONS OF THE PRESS.

"In these days of surgical dominance, when operation is urged for every growth or blemish that one chooses to call precancerous, it requires courage to call for delay, to ask the surgeon to stay the knife and see what nature, aided by rational living, will do to arrest the progress of the disease. Dr. Buckley has this courage, and his courage is based upon experience. The book is well written, extremely interesting and moreover provides food for a great deal of deep thought."—*Medical Record*.

"The millenium, in so far as the cure and prevention of cancer, has come if we all could only attain the results of the writer of the attractive and readable volume under discussion."—*Amer. Jour. Med. Sciences*.

"The author's theory deserves judicial consideration, since it represents a logical and rational contribution to the literature of the subject."—*Boston Med. and Surg. Journal*.

"Dr. Duncan Bulkley will meet with the assent of many of his readers when he observes that from the enormous work which has been done on cancer with the microscope and test tube, it would seem sometimes that research workers have become somewhat myopic, and are still not sufficiently farsighted to recognize the true value of statistical studies and clinical observation."—*British Med. Jour.*

"The book is to be recommended as well and clearly written by one whose opinion bears weight."—*Edinburgh Med. Jour.*

"The book will repay perusal."—*Liverpool Med.-Chir. Jour.*

BOTANIC DRUGS: Their Materia Medica, Pharmacology and Therapeutics. By Thomas S. Blair, M.D., Editor Medical Council; Author of "Public Hygiene," "A Practitioner's Handbook of Materia Medica and Therapeutics," and "Pocket Therapeutics;" formerly neurologist to Harrisburg (Pa.) Hospital. Large type, fully indexed, 394 pages. Price, \$2.00. Cincinnati. Therapeutic Digest Pub. Co., 1917.

Fischelis a year ago drew attention to the increasing scarcity of imported medicinal products, and urged the utilization of available native supplies. He made an earnest plea for a larger use of galenicals, especially of indigenous plant origin. Prof. A. Tschirch, of the University of Berne, in a recent address, deprecated the increasing use of the so-called active principles and synthetic medicaments, and that many physicians have disaccustomed themselves to the use of plant drugs. The wish expressed by him in London in 1909, "Let us go back to drugs," has already met with a larger echo than he dared hope at that time.

Blair has presented in this book in concise form a convincing argument for the restudy and enlarged use of galenicals. He is a trained pharmacologist as well as an active practitioner of medicine. He is thus competent to weigh the evidence presented from the research laboratory and that of the bedside. The author frankly admits he "realizes the

fact most acutely that it is quite impossible, in our present state of knowledge, to prepare a truly scientific text" on the subject. But this deplorable state is, in a measure, a reproach to modern medicine. Galenicals have been used empirically for over 3,000 years, and their scientific study is a common duty. All of the botanic drugs in common use are described, with critical review of their therapy. The exact dose is given, how best employed and the distinctions in the use of allied drugs are gone into thoroughly. While there is evident a strong note of personal predilection owing to intimate study of various galenicals, the author is fair in giving due credit to the opinions of others. Blair's book is one of the most practical, sensible and dependable yet published on the subject. It has appeared at a very opportune time. It behooves every physician who has the interests of his patient at heart to get a copy, and again become familiar with botanic drugs.

THE MEDICAL CLINICS OF CHICAGO. Volume II, Number VI (May, 1917). Octavo of 252 pages, 46 illustrations. Philadelphia and London: W. B. Saunders Company, 1917. Published Bi-Monthly. Price per year: Paper, \$8.00; Cloth, \$12.00.

ASTHMA: Presenting an Exposition of the Nonpassive Expiration Theory. By Orville H. Brown, A.B., M.D., Ph.D., Assistant Professor of Medicine, St. Louis University. Foreword by George Dock, Sc.D., M.D. Thirty-six engravings. Cloth, 330 pp. C. V. Mosby Co., St. Louis Mo.

This monograph is the result of the author's nine years of study of the subject.

With the great range of special investigation in all departments of medicine, and the effort to explain all obscure features by applying new discoveries in every field of science, comes the need of making broad surveys—of gathering in a connected form the present status of various clinical problems.

The conditions included in the term "asthma" might well excite efforts at general study, and Dr. O. H. Brown has earned the gratitude of the profession by presenting a comprehensive and up-to-date study of them. The writer has had the privilege of following Dr. Brown's research over some years and of reading his manuscript, and has been impressed by the accuracy of the author's clinical work, and by the fullness and symmetry of the literary production. The literature, both monographic and special, is well presented, the theories of the disease are clearly set forth and critically discussed. The author's theory of asthma, named by him the "Nonpassive Expiration Theory," is stated clearly and in an admirable spirit. It would be superfluous to give an analysis of this theory here, since the chapter well repays careful study, and bears directly on the author's method of treatment, which is clearly presented and reveals the

well-informed, accurate, and conscientious therapist. The student and the practitioner can find in this book a true picture of the previous speculations and present knowledge of asthma expressed clearly and concisely, a trustworthy guide in the examination and treatment of actual patients, and many suggestions for fresh explorations by the bedside and in the laboratory.

THE INTERNATIONAL CLINICS—QUARTERLY. Edited by H. R. M. Landis, M.D., Philadelphia. Volume I. Twenty-seventh Series, 1917. Price, \$2.00. J. B. Lippincott Co., Philadelphia.

This first volume of the 27th series of this splendid "Clinic" maintains and in some respects exceeds the previous excellent standard that has prevailed during the past twenty-six years.

THE ROENTGEN DIAGNOSIS OF DISEASES OF THE ALIMENTARY CANAL. By Russell D. Carman, M.D., Head of Section on Roentgenology, Division of Medicine, Mayo Clinic and Albert Miller, M.D., First Assistant in Roentgenology at the Mayo Clinic. Octavo of 558 pages with 504 original illustrations. Philadelphia and London: W. B. Saunders Company, 1917. Cloth \$6.00 net; Half Morocco, \$7.50 net.

This work is one of the most complete and authoritative treatise of the subject. The author's extended and voluminous experience at once commands attention. There is compiled the well established facts of the subjects discussed. The experiences and finds that have been found proven and worth while have been selected and systematically arranged and substantiated by voluminous personal observations. The illustrations are numerous, clear and pictorially emphasize the text.

It may safely be concluded that this volume presents and sums up all that is known and worth while in the diagnosis of diseases of the alimentary canal by means of roentgen ray findings.

DIAGNOSIS FROM OCULAR SYMPTOMS. By Matthias Lanckton Foster, M.D., F.A.C.S. Cloth, 470 pp. Rebman Company, New York.

This volume will prove to be of permanent reference value to every practitioner. It is a systematic guide to diagnosis. It takes up the symptoms and physical findings and from them the differentiation is made and the true condition determined. It is actually a clinical presentation and enables the physician to determine the true condition from the clinical findings.

As such the work is of exceptional value to the general practitioner for it enlightens him so that he will be able to recognize the ocular condition that confronts him. We are unfamiliar with any work that possesses so much practical and applicable instruction. It is indeed valuable to the literature.

THE DIAGNOSIS AND TREATMENT OF ABNORMALITIES OF MYOCARDIAL FUNCTION. By T. Stuart Hart, A.M., M.D., Assistant Professor of Medicine College of Physicians

and Surgeons, Columbia University. Illustrated, 248 engravings. Cloth, 320 pp. The Rebman Co., New York.

This is an excellent work that approaches the subject from the clinical side and lays stress upon practical important features. Numerous graphic tracings are presented and their discussion enables one to grasp a clear practical viewpoint.

The volume merits one's careful study, for by so doing there will result a better knowledge of altered myocardial function.

REST SUGGESTION AND OTHER THERAPEUTIC MEASURES IN NERVOUS AND MENTAL DISEASES. Francis X. Dercum, A.M., M.D., Ph.D., Professor of Nervous and Mental Diseases, Jefferson Medical College. Second Edition, Cloth, 395 pp. P. Blakeston's Son & Co., Philadelphia.

The author has unfolded in a systematic manner the problems presented by the exercise of function, rest and various fatigue stages. Likewise there is imparted a clear interpretation of the various neuroses. Emphasis has been laid upon physiological methods and the employment of purely medical treatment.

The result is a splendid work on a subject that merits more than a dose of bromide to attain normal restoration. It is indeed a compilation that will enable the practitioner to acquire a better insight in the treatment of nervous and mental diseases that will enable him to institute effective methods of treatment.

MEDICAL STATE BOARD QUESTIONS AND ANSWERS. By R. Max Goepp, Professor of Clinical Medicine at the Philadelphia Polyclinic, Assistant Professor of Clinical Medicine, Jefferson Medical College. Fourth Edition, Thoroughly Revised. Octavo Volume of 724 Pages. W. B. Saunders Company, Philadelphia and London, 1917. Cloth, \$4.25 net.

This book as its title indicates, is offered as a material help to students and practitioners who are preparing for state board examinations. What questions may be propounded in the future, we are not able to state. This book is only able to present the nature of the questions submitted in the past, and their proper answer, which will be very helpful in preparing for what may come up in the future. After the applicant has adequately prepared for examination, he may properly fortify himself by a careful study of what the probable nature of the examination may be. A well qualified candidate may fail by being taken by surprise by his ignorance of the character of the examination to which he may be submitted.

This edition includes the later subjects included in a state board examination, physics, chemistry and bacteriology; and will be particularly helpful to the practitioner who has been out of school a few years and now seeks an opportunity to prepare for a new examination in another state.

Frostilla.—The lotion for chapped hands is, according to the *Druggist Circular*, a quince seed mucilage containing alcohol, glycerin and perfume. (*Jour. A.M.A.*, May 5, 1917, p. 1341.)

Miscellany

MORTALITY OF MICHIGAN, MAY, 1917.

There were 4,232 deaths reported to the Department of State as having occurred in the State of Michigan during the months of May, 1917. This number corresponds to an annual death rate of 15.8 per 1,000 estimated population. In addition to the above, there were 246 stillbirths returned as deaths.

By ages there were 627 deaths of infants under one year of age; 260 deaths of children aged 1 to 4 years, both inclusive; and 1,338 deaths of elderly persons aged 65 years and over. The number of deaths of elderly persons shows an increase as compared with the preceding month.

Important causes of death were as follows: Pulmonary tuberculosis, 267; other tuberculosis, 62; typhoid fever, 35; diphtheria and croup, 76; scarlet fever, 43; measles, 45; whooping cough, 25; pneumonia, 426; diarrhea, enteritis under two years, 98; meningitis, 47; influenza, 44; cancer, 248; violence, 273.

As compared with the number of deaths for the preceding month an increase is noted in the number of deaths returned from pulmonary tuberculosis, typhoid fever, diphtheria, measles, whooping cough, diarrhea, meningitis, cancer and violence. A slight decrease is noted in the number of deaths returned from other tuberculosis, scarlet fever, pneumonia, and influenza.

In addition to the important causes noted above there were 2 deaths from tetanus, 1 from Anthrax, 1 from chicken pox and 1 from poliomyelitis.

The different State Institutions (Hospitals and Asylums), reported deaths as follows: Traverse City, 29; Kalamazoo, 22; Pontiac, 14; Newberry 5; Soldiers' Home, 16; Wayne County House, 60. The death rates for the above cities shown in the table of cities include all deaths, transient and others. In a majority of instances the transient deaths should not be charged to the particular city in which institution is located. Following are the corrected rates with deaths occurring in institutions, deducted—Traverse City, 11.7; Kalamazoo, 10.0; Lapeer, 7.8; Pontiac, 18.2; Ann Arbor, 20.4.

The distribution of deaths referred to above by counties and by cities as well as by the most important causes of death may be seen in the table shown in the Monthly Bulletin of Vital Statistics, which is published by the Department, and is for free distribution.

Upon referring to the table of counties we find the greatest mortality rate is for the County of Luce. This county shows a rate of 25.6 per 1,000 estimated population. Crawford County with a rate of 44.0 per one thousand estimated population shows the highest birth rate for the month.

There were 6,601 births returned to the Department as having occurred during the month of May. This number corresponds to an annual birth rate of 24.6 per 1,000 estimated population. A decrease of 421 births is noted as compared with the month immediately preceding. In addition to the above there were 271 stillbirths returned as births.

Nutrolactis and Goat's Rue.—Drugs which stimulate the secretion of milk are unknown to science. Yet the proprietary Nutrolactis (The Nutrolactis Company) is claimed to increase the milk supply of nursing mothers. Since dependence on a preparation of this kind is liable to cause neglect of the only means of increasing the milk supply of nursing mothers—care of the general health and a sufficient quantity of proper food—Professor A. J. Carlson and Marian Lewis of the Hull Physiologic Laboratory of the University of Chicago studied this proprietary and the drug goat's rue (*Galega officinalis*), which the proprietors of Nutrolactis hint as being the potent constituent to determine their effects on nursing animals with the intention of extending the study to nursing mothers if the animal trials warranted this. The animal experiments showed that neither Nutrolactis nor goat's rue had any effect on the milk supply of nursing goats or dogs. The Council on Pharmacy and Chemistry, which had caused the study to be made, endorsed the work of Carlson and Lewis, and held that the claimed galactagogue effects of Nutrolactis and the drug goat's rue had not been substantiated. (*Jour. A.M.A.*, May 26, 1917, p. 1570.)

The Luetin Test.—Confirmatory of previous investigations, H. N. Cole and H. V. Parysek finds that some non-syphilitics respond positively to the luetin test and that in those non-syphilitics who do not respond spontaneously the reaction can generally be provoked by iodides. They also demonstrated that the reaction may be provoked by potassium nitrate and potassium bromide. Proving that the potassium ion in the potassium iodide and bromide was not concerned in the reaction, they found that the luetin test may be provoked by sodium bromide, sodium iodide and calcium bromide (*Jour. A.M.A.*, April 14, 1917, p. 1089).

Pepsodent.—Wm. J. Gies writes that Pepsodent is a dentifrice widely advertised as a mucin digestant. In a research conducted for the First District Dental Society of the State of New York, Professor Gies and Miss Franke found that the digestive claims were not warranted in any degree. Gies holds that there is about as much common sense in the proposed use of pepsodent for this purpose as there is in the oral administration of a few grains of lactopeptine to improve impaired tryptic digestion in the intestines. (*Jour. A.M.A.*, April 28, 1917, p. 1278).